

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9433

CERTIFICATE OF DEATH

09405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4003 Longfellow Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Irene Middle Edith Last Akers				4. DATE OF DEATH Month August Day 28 Year 19 60-			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1904	
9. AGE (In years lost birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Fred Day				14. MOTHER'S MAIDEN NAME Mary Bruseke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT John H Akers				Address Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 199.1 IMMEDIATE CAUSE (a) Parcoma of 29th March Vertebrae DUE TO (b) Generalized metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH
21. I certify that I attended the deceased from Jan 4 , 19 60 , to Aug 28 , 19 60 , that I last saw the deceased alive on Aug 28 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 GALLATIN ST. DATE SIGNED ACTUAL SIGNATURE Aaron Deitz M.D. PHYSICIAN'S NAME (Type) AARON DEITZ, M.D. HYATTSSVILLE, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 1, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR SEP 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1405 Second Street

1405 Second Street

John H. Allen, Westville, N.C.

at

Westville, N.C.

Westville, N.C.

Westville, N.C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60 et.

9448

09406

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sheverly c. LENGTH OF STAY IN 1b Prince George General Hospital d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 4720 68th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Henry Albright Sr.		4. DATE OF DEATH Month Day Year Aug. 2 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875 July 19, 1837
9. AGE (In years last birthday) 87 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Railway Clerk	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? Us A	
13. FATHER'S NAME Henry A Albright		14. MOTHER'S MAIDEN NAME Margaret Ferrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 719-09-7215	
17. INFORMANT Anna Belle Albright		Address Woodlawn Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Hypertension, Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH 1 hr 1.5 hr
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-12-60 19 to 8-2 19 60 , that (I) (we) last saw the deceased alive on 7-28 19 60 , and that death occurred on 28 M, from the causes and on the date stated above.			
22a. SIGNATURE John P. Clum		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John P. Clum		22d. ADDRESS Hyattsville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Aug 4, 1960	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE AUG 8 '60		25b. REGISTRAR'S SIGNATURE Charles L. Evans	

1000

CERTIFICATE OF DEATH

0418

Place of Birth

Age

Place of Birth

County

Place of Death

Place

Place

Place

Place

Place

Place

Place

Place

Place

Place

Witnessed by
Signature of Witness

1000
1000

1000

1000

1000

1000

Signature of Witness

John P. Clark

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9443 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09407

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tokoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tokoma Park	
c. LENGTH OF STAY IN 1b 40 Yrs.		d. STREET ADDRESS 428 Ethan Allen Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 428 Ethan Allen Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Elwood Last Ashford		4. DATE OF DEATH Month August Day 30, Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Franklin Ashford		14. MOTHER'S MAIDEN NAME Georganna Grimes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11	
17. INFORMANT Charles R. Ashford		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bronchogenic Ca</u> (c) <u>of Lung</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE DAYTON O WATKINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O WATKINS		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/2/60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE SEP 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
SIGNATURE OF MEDICAL EXAMINER		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF CORONER		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF JURY		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF CLERK		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF ATTORNEY		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF JAILER		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF PRISONER		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF JURY		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF CLERK		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF ATTORNEY		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF SHERIFF		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF JAILER		DATE		TIME		PLACE		HOSPITAL		CITY	
SIGNATURE OF PRISONER		DATE		TIME		PLACE		HOSPITAL		CITY	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 4 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9722 Wichita Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George Curtis Atkins		4. DATE OF DEATH Month August Day 14 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1919		9. AGE (In years last birthday) 41 yrs. Months 4 Days 18		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Electronics		11. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME Curtis W. Atkins			14. MOTHER'S MAIDEN NAME Ici V. Webster				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 224-03-8647		17. INFORMANT Address Mrs Naomi Atkins, Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Rupture of the liver (a), stating the underlying cause last. (c) EXTRAHEPATIC BILIRUBINEMIA					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile that ran into another car					
20c. TIME OF INJURY Hour 8:20 a.m. 8/13/60 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) College Park P.G. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/14/60			
EXAMINER'S NAME (Type) James I. Boyd		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16, 1960		22c. NAME OF CEMETERY OR CREMATORY Dayton Cemetery			
		22d. LOCATION (City, town, or country) (State) Dayton, Virginia.					
23. FUNERAL DIRECTOR LINDSEY & SONS 473 S. Main St. Harrisonburg, Va. REC'D BY REGISTRAR DATE AUG 16 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9449 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **09408**

44188

MAINTAINING DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-111111

(M)

Prince George's Maryland

Choverly 4 hours
Prince George's General Hospital 9725 Wisconsin Avenue
x

Male George's
Wife George's
March 27, 1919

Mechanics Electronics Virginia
Carlisle W. Atkins
1st V. Webster

22-407-267 Mrs Naomi Atkins, Same as # 2

(1)

XXXXXXXXXXXXXXXXXXXX
Porture of the liver
Hemorrhage and shock

Driver of an automobile that ran into another car
Circumstances of the liver

8:30 8/13/60 x Street College Park, D. C.
x x x

8/14/60 x
James I. Boyd

Funeral Home, 1500 Eastern Cemetery
Hart Funeral Home, 1500 Eastern Cemetery
x

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

4 1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9524 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09409
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6014-67 Place				d. STREET ADDRESS 16014-67d Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mabel Enough Bane				4. DATE OF DEATH Month Day Year Aug 6 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. E	
13. FATHER'S NAME Helron E. Burton				14. MOTHER'S MAIDEN NAME Agnelina Cady			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Louise Fletcher, same as #2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Aug 6, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home. Washington D.C.				24a. REC'D BY REGISTRAR DATE AUG 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thaw	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 15 1925</i>		PLACE OF DEATH <i>Home</i>	
CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>			
MANNER OF DEATH <i>Natural</i>			
SIGNATURE OF EXAMINER <i>John Doe</i>			
DATE OF EXAMINATION <i>Jan 15 1925</i>			
PLACE OF EXAMINATION <i>Home</i>			
CITY <i>Baltimore</i>			
COUNTY <i>Harford</i>			
STATE <i>Md.</i>			
COUNTRY <i>U.S.A.</i>			
SIGNATURE OF DECEASED <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1925</i>			
PLACE OF SIGNATURE <i>Home</i>			
CITY <i>Baltimore</i>			
COUNTY <i>Harford</i>			
STATE <i>Md.</i>			
COUNTRY <i>U.S.A.</i>			
SIGNATURE OF WITNESS <i>John Doe</i>			
DATE OF SIGNATURE <i>Jan 15 1925</i>			
PLACE OF SIGNATURE <i>Home</i>			
CITY <i>Baltimore</i>			
COUNTY <i>Harford</i>			
STATE <i>Md.</i>			
COUNTRY <i>U.S.A.</i>			

9450

Item 16 Filing 8-11-99

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9525

09411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural — Bowie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural — Bowie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Pete Barnes		4. DATE OF DEATH Aug 16 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22 1883
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 28-03-9262	
INFORMANT Rachel Barnes		Address Bowie Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X Congestive Heart Failure DUE TO (b) Hypertension DUE TO (c) Gen. Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 wk 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955, to Aug 16 1960, that I last saw the deceased alive on Aug 16 1960, and that death occurred at 3:44 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Henry A. Wise, M.D.		ADDRESS (Street, city or town, state) 149 9th St Bowie Md	
PHYSICIAN'S NAME (Type) Henry A. Wise		DATE SIGNED 8/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-19-60	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cem.		22d. LOCATION (City, town, or county) (State) Bowie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson's Mortuary, 34 Lafayette Ave., Annapolis Md.		24a. REC'D BY REGISTRAR DATE AUG 18 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11111

CERTIFICATE OF DEATH

2325

1

1

[Faint, illegible text and markings on a lined form, likely a death certificate. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
9451
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09412

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. LENGTH OF STAY IN 1b <u>78 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENERAL Hospital</u>				d. STREET ADDRESS <u>4205 Ogletheape St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MILDRED</u>		First <u>M</u> Middle <u>B</u> Last <u>BARTON</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3rd</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25, 1918</u>		9. AGE (In years last birthday) yrs. <u>42</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone operator answering service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Luxemburg Co., Va.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James H. Vaughan</u>			14. MOTHER'S MAIDEN NAME <u>Lois Sheffield</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>230-18-6331</u>		17. INFORMANT <u>Lois Vaughan, mother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> <u>152.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cidemo carcinoma of the ascend colon</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> 19 <u>60</u> to <u>8/3</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>8/3</u> 19 <u>60</u> , and that death occurred <u>11 A.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>F. Flores</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>F. FLORES</u>				22d. ADDRESS <u>PRINCE GEORGE'S HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/6/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kalley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>			

1011

DEPARTMENT OF HEALTH

1243



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "DEPARTMENT OF HEALTH" and "DEPARTMENT OF DEATH" are visible.]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9526

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>44 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>56 Horse Shoe Drive</u>				d. STREET ADDRESS <u>156 Horse Shoe Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Batton</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1918</u>		9. AGE (In years last birthday) <u>42 yrs.</u>	10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Producer</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-C</u>	
13. FATHER'S NAME <u>William Henry Batton</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Mump</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>574-07-617</u>		17. INFORMANT <u>Mrs Edith Batton, same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> 978 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Gun shot wound of head</u> c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head with a 22 Cal. rifle</u>					
20c. TIME OF INJURY Month, Day, Year <u>Aug 3 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Clinton Pz Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Aug 3, 1960</u>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Gaila S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9527

CERTIFICATE OF DEATH

09414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST HEIGHTS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLCREST HEIGHTS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2210 JAMESON ST.</u>		d. STREET ADDRESS <u>12210 JAMESON ST</u>	
3. NAME OF DECEASED (Type or print) First <u>Regina</u> Middle <u>M.</u> Last <u>BECK</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 19, 1882</u>
9. AGE (In years, lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANCIS GUTH</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE HEUTCHEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>FRANK GUTH 2210 JAMESON ST</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/1, 1958</u> to <u>8/11, 1960</u> , that I last saw the deceased alive on <u>8/10, 1960</u> , and that death occurred at <u>1:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David Lenarduzzi</u> M.D.		ADDRESS (Street, city or town, state) <u>2901 Fairlane St SE</u> DATE SIGNED <u>8/11/60</u>	
PHYSICIAN'S NAME (Type) <u>David Lenarduzzi</u>		<u>Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-13-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab</u> ADDRESS <u>2101 Franklin Ave Balto. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1
FOR STATE
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

9452 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS Box 2085			
3. NAME OF DECEASED (Type or print) Earl Mathew Belt				4. DATE OF DEATH Month August Day 13 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 -18 -43	
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months 17 Days 17		IF UNDER 24 HRS. Hours 17 Min. 17			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A							
13. FATHER'S NAME Samuel Belt				14. MOTHER'S MAIDEN NAME Susie(Belt) Sellmen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give year or dates of service)			
17. INFORMANT Annette Belt				Address Box 2085 Upper Marlboro, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Severance of the Iliac Artery - XXXX right DUE TO (c) Gdn shot wound of the abdomen PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during an altercation			
20c. TIME OF INJURY Month, Day, Year Aug. 13/60 Hour 5:30 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sunset Inn				20f. (City or town) Upper Marlboro (County) P. G. Md (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 8/14/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-16-60			
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel				22d. LOCATION (City, town, or country) Upper Marlboro, Md. (State)			
23. FUNERAL DIRECTOR Myrtle K. Rollins				ADDRESS 4339 Hunt Pl., N.E., D.C.			
24a. REC'D BY REGISTRAR AUG 16 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

7

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9453

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09416

1. PLACE OF DEATH a. COUNTY Georges MARYLAND Prince		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Maryland Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sadie First R Middle Bickley Last		4. DATE OF DEATH Month Aug. Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 7, 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Franz Rankin		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT G.orge Bickley		Address Landover Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO 420.00 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Insufficiency DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Chronic Cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1960 to Aug. 15, 1960 , that (I) (we) last saw the deceased alive on 1960 , and that death occurred on Aug. 13, 1960 , from the causes and on the date stated above.			
22a. SIGNATURE A Deitz		22b. DATE SIGNED 8-15-60	
22c. PHYSICIAN'S NAME (Type) A Deitz		22d. ADDRESS Hyattsville Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/18/60	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
25a. REC'D BY REGISTRAR AUG 19 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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9528

CERTIFICATE OF DEATH

09417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Englewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Englewood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Grimes Rest Home</u>		d. STREET ADDRESS <u>6003 Keel St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>L. Borders</u> Last <u></u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marion, N.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Crisp</u>		14. MOTHER'S MAIDEN NAME <u>Annie Carson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>James W. Crisp - 6003 Keel St.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> 334-X DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Natural conditions of age and heart</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>1-7-1960</u> to <u>8-29-1960</u> that I last saw the deceased alive on <u>8-29-1960</u> and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Robinson</u> M.D.		ADDRESS (Street, city or town, state) <u>1001 Eastern Ave., N.C.</u>	
PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u>		DATE SIGNED <u>8/29/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-30-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Marion N.C.</u>	22d. LOCATION (City, town, or county) (State) <u></u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henny L. Washington + Sons</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

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CENTRAL BANK OF INDIA

1941

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. Some words like "London" and "Cheque" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9454

09418

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3210 Perry Street			
3. NAME OF DECEASED (Type or print) First John Middle T Last Bostick				4. DATE OF DEATH Month Aug. Day 4 Year 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 5 - 1905	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Thomas Bostick				14. MOTHER'S MAIDEN NAME Mary Brewer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 mos						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m. Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Aug. 2 19 60 , to Aug. 4 19 60 , that (I) (we) last saw the deceased alive on Aug. 4 19 60 , and that death occurred at 5:10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas G. Maloney M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STATE PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4 Aug 60	
22c. PHYSICIAN'S NAME (Type) THOMAS G. MALONEY				22d. ADDRESS 2205 - Cheverly Ave. Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 5th-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros				25a. REC'D BY REGISTRAR HOPE R. BROS		25b. REGISTRAR'S SIGNATURE Charles S. Hanna	

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CERTIFICATE OF DEATH

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John James Bonfield

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John James Bonfield

may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled hereby the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09419

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 16 Hr			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Junction				d. STREET ADDRESS 02X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen		First M Middle Boswell Last		4. DATE OF DEATH Aug. 25		Month 25 Day 19 Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Centerville, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Clark Allen				14. MOTHER'S MAIDEN NAME Mary A. Reener			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Jane M. Allen Address Annapolis Junction, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart & coronary vessels DUE TO (b) Arteriosclerosis of the legs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 d. 4 d.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 20 19 60 to Aug 25 19 60 , that (I) (we) last saw the deceased alive on Aug 25 19 60 , and that death occurred at 6 AM on the causes and on the date stated above.							
22a. SIGNATURE Robert S. McCeney MD				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert S. McCeney MD				22d. ADDRESS 402 Main St Laurel, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 27, 1960		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem		23d. LOCATION (City, town, or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE DeWitt Donaldson				ADDRESS Laurel, Md.		25a. REC'D BY REGISTRAR DATE AUG 30 '60	
				25b. REGISTRAR'S SIGNATURE Arthur J. Evans			

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U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9508

CERTIFICATE OF DEATH

09420

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.				c. LENGTH OF STAY IN IB 4 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First James Middle Samuel Last Brady sr				4. DATE OF DEATH Month August Day 4 , Year 19 60					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 15, 1890			
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U S A									
13. FATHER'S NAME John A Brady				14. MOTHER'S MAIDEN NAME Rosella Henry					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Gertrude S Brady High Bridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute enterocolitis 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peritonitis (c) Perforated diverticulitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arthritis - Gen -								INTERVAL BETWEEN ONSET AND DEATH 4 days 1 day 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Laurel, Md.				20g. (County) Prince George's		20h. (State) Md.			
21. I certify that I attended the deceased from 8/1 , 19 60 , to 8/4 , 19 60 , that I last saw the deceased alive on 8/4 , 19 60 , and that death occurred at 4:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Laurel Md DATE SIGNED 8/4/60									
ACTUAL SIGNATURE B P Warren				M.D. Laurel Md					
PHYSICIAN'S NAME (Type) B. P. Warren				Laurel, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR AUG 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

5508

NAME OF DECEASED John Smith		SEX Male		AGE 45	
DATE OF DEATH Jan 1, 1910		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Myocardial Infarction		PERIOD OF ILLNESS 2 weeks	
PLACE OF BIRTH Maryland		DATE OF BIRTH Dec 1, 1864		PLACE OF BIRTH Maryland	
MARRIAGE Married		DATE OF MARRIAGE Jan 1, 1885		PLACE OF MARRIAGE Maryland	
OCCUPATION Farmer		EDUCATION High School		RELIGION Roman Catholic	
MILITARY SERVICE None		NAVY SERVICE None		OTHER SERVICE None	
SIGNATURE OF DECEASED John Smith		SIGNATURE OF WITNESS John Smith		SIGNATURE OF PHYSICIAN John Smith	
DATE OF SIGNATURE Jan 1, 1910		DATE OF SIGNATURE Jan 1, 1910		DATE OF SIGNATURE Jan 1, 1910	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 3, Film G-273 10/21/60.cac									
9529 CERTIFICATE OF DEATH									
09421									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, WASH 25, DC					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 1222 U Street SE, Apt 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last DEREK NEWBORN JUSTIN BRAKE					4. DATE OF DEATH Month Day Year AUGUST 18 19 60				
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 AUGUST 1960		9. AGE (In years last birthday) yrs. 1 Months 1 Days 2 Hours 50 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10b. KIND OF BUSINESS OR INDUSTRY NONE			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME DEWEY LEE BRAKE					14. MOTHER'S MAIDEN NAME ROBERTA ANN OYLER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) N/A		INFORMANT PATIENT'S CHART		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 773X IMMEDIATE CAUSE (a) RESPIRATORY DISTRESS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 25 HOURS								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 17 AUGUST, 19 60 , to 18 AUGUST, 19 60 , that I last saw the deceased alive on 18 AUGUST, 19 60 , and that death occurred at 1:20 PM , from the causes and on the date stated above.									
ACTUAL SIGNATURE John A. Moore			ADDRESS (Street, city or town, state) DATE SIGNED ANDREWS AIR FORCE BASE 18 AUG 60						
PHYSICIAN'S NAME (Type) JOHN A. MOORE, MAJ USAF (MC)			USAF HOSPITAL ANDREWS, WASHINGTON 25, D. C.						
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-19-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Morgue			22d. LOCATION (City, town, or county) (State) Washington D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE Note from: ADDRESS Andrews A. L. B.					24a. REC'D BY REGISTRAR AUG 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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may be filed by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09422

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltersville</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. STREET ADDRESS <u>111418 Cherry Hill Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11418 Cherry Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>L.</u> Last <u>BRIGGS, JR.</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1882</u>
9. AGE (In years, lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Industrial Education U. of Md. (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philadelphia Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry L. Briggs</u>		14. MOTHER'S MAIDEN NAME <u>Elegabeth ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Mrs. Mary C. Briggs. (Same as #2)</u>		Address <u>(Same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Chronic Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>C.S. C.V. Disease</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3d - 5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> to <u>8/11</u> 19 <u>60</u> that (I) (we) lost saw the deceased alive on <u>8/9</u> 19 <u>60</u> and that death occurred at <u>6</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. M. Warren</u>		22b. DATE <u>8/11/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		22d. ADDRESS <u>Laurel, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 13, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George County Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>		25a. REC'D BY REGISTRAR <u>AUG 15 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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RECEIVED
CERTIFICATE OF DEATH

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[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Name", "Age", "Sex", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]

9444

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09423

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>S4 Sakoma Park</i>			
c. LENGTH OF STAY IN 1b <i>2+ years</i>				d. STREET ADDRESS <i>17219 Minter Place</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7219 Minter Place</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>BESSIE</i> Middle <i>-</i> Last <i>BRITT</i>				4. DATE OF DEATH Month <i>AUG</i> Day <i>7</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 23, 1880</i>		9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>New York State</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Golder</i>				14. MOTHER'S MARDEN NAME <i>Not Available</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Harold B. Colvin (same as #2)</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Heart Disease</i> <i>44-3X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>old</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6 May 1953</i> to <i>7 Aug 1960</i> , that (I) (we) last saw the deceased alive on <i>6 Aug 1960</i> , and that death occurred at <i>5:30</i> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Ernest A. Sarao</i>				22b. DATE SIGNED <i>7 Aug 60</i>		22c. PHYSICIAN'S NAME (Type) <i>ERNEST A. SARAO</i>	
22d. ADDRESS <i>7006 New Hampshire Ave. S.P.M.D.</i>				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>Aug 10, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Walters</i>				25a. REC'D BY REGISTRAR <i>Arthur S. Walters</i> DATE <i>AUG 9 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Walters</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10152

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9456

09424

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 1/2 hr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Englewood d. STREET ADDRESS 6010 Pratt St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cora First Brooks Middle Last			4. DATE OF DEATH Month Aug. Day 4 Year 18 60				
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1895		9. AGE (In years last birthday) 65 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Mary's Co. Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Thomas			14. MOTHER'S MAIDEN NAME Cecelia Dyson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 hours					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 3 1960, to Aug. 4 1960, that (I) (we) last saw the deceased alive on Aug. 4 1960, and that death occurred at 3 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas J. Maloney		22b. DATE SIGNED 4 Aug 60		22c. PHYSICIAN'S NAME (Type) Arthur S. Kraus			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/9/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National			
23d. LOCATION (City, town, or county) (State) Arlington, Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		25a. REC'D BY REGISTRAR AUG 8 60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS 30 H Street, N.E. D.C.					

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CERTIFICATE OF DEATH

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AGE

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PLACE OF BIRTH

DATE OF BIRTH

CAUSE

DATE

PLACE OF DEATH

DATE OF DEATH

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

Charles H. Henshaw

8/11/19

Charles H. Henshaw

8/11/19

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Pr. Geo.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanell</i>				c. LENGTH OF STAY IN 1b <i>24 years</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanell</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>122 Lafayette Avenue</i>				d. STREET ADDRESS <i>122 Lafayette Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Hollis</i> Middle <i>Teel</i> Last <i>Brown</i>				4. DATE OF DEATH Month <i>8</i> Day <i>24</i> Year <i>1960</i>							
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 23, 1893</i>		9. AGE (In years lost birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>realtor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>self-employed</i>				11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Peter Brown</i>				14. MOTHER'S MAIDEN NAME <i>Ida Josephine Teel</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>—</i>				17. INFORMANT <i>Jeanne B. Barbours Lanell Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerosis</i> DUE TO (c) <i>—</i>										INTERVAL BETWEEN ONSET AND DEATH <i>1 min.</i> <i>10 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> 19 <i>56</i> to <i>Aug</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>8/24</i> 19 <i>60</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Frank L. Weaver Jr</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>8/25/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>FRANK L. WEAVER JR.</i>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>8/27/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>McWitt Davidson, Lanell, Md</i>						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	
						DATE <i>AUG 30 '60</i>					

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9531
CERTIFICATE OF DEATH

09426

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <u>Virginia</u> b. COUNTY <u>Gloucester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Southern Md. Hospital Center</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Schley P.O.</u>	
d. STREET ADDRESS <u>83X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LUCY Woodland BROWN</u>		4. DATE OF DEATH Month Day Year <u>8 - 7 - 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jeff Woodland</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>MRS Edna Hays</u> Address <u>UPPER MARLBOR R.D. Box 1203 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-7</u> , 19 <u>60</u> , to <u>8-7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-7</u> , 19 <u>60</u> , and that death occurred at <u>8:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred R. Lapin</u> M.D.		ADDRESS (Street, city or town, state) <u>CLINTON, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Singleton</u>		22d. LOCATION (City, town, or county) (State) <u>Gloucester, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnnie B. ...</u>		24a. REC'D BY REGISTRAR <u>AUG 9 1960</u>	
ADDRESS <u>Johnnie B. ...</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

1948

CERTIFICATE OF DEATH

1948

NAME

DATE

TIME

PLACE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

TIME OF INTERMENT

PLACE OF INTERMENT

DATE OF CREATION

DATE OF REGISTRATION

TIME OF REGISTRATION

PLACE OF REGISTRATION

DATE OF CLOSURE

DATE OF OPENING

TIME OF OPENING

PLACE OF OPENING

DATE OF REMOVAL

DATE OF RETURN

TIME OF RETURN

PLACE OF RETURN

DATE OF DESTRUCTION

DATE OF REPAIR

TIME OF REPAIR

PLACE OF REPAIR

DATE OF RECONSTRUCTION

DATE OF RENOVATION

TIME OF RENOVATION

PLACE OF RENOVATION

DATE OF REDEMPTION

DATE OF REDEMPTION

TIME OF REDEMPTION

PLACE OF REDEMPTION

DATE OF REDEMPTION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9457 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09427
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AGUASCO</u> X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>			d. STREET ADDRESS <u>no</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>SHILEY ANN BROWN</u>			4. DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 23, 1959</u>		9. AGE (in years last birthday) <u>8 months</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>agwasco md</u>	12. CITIZEN OF WHAT COUNTRY? <u>usa</u>
13. FATHER'S NAME <u>GEORGE NELSON Brown</u>			14. MOTHER'S MAIDEN NAME <u>Myrtle Boris</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>George N Brown</u> Address <u>agwasco md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypoadrenalism</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Interstitial Pneumonia</u> DUE TO (c) <u>2 week</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>no</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>		20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Dayton O Watkins</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-25-60</u>
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	
22d. LOCATION (City, town, or county) <u>Agwasco, Md.</u>		22e. (State) <u>MD</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Kneass</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

00157

4457 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. TIME OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. OCCUPATION [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>		<p>9. MANNER OF DEATH [Faint text]</p>	
<p>10. SIGNATURE OF MEDICAL EXAMINER [Faint text]</p>		<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF CORONER [Faint text]</p>	
<p>13. SIGNATURE OF JURY [Faint text]</p>		<p>14. SIGNATURE OF JURY [Faint text]</p>		<p>15. SIGNATURE OF JURY [Faint text]</p>	
<p>16. SIGNATURE OF JURY [Faint text]</p>		<p>17. SIGNATURE OF JURY [Faint text]</p>		<p>18. SIGNATURE OF JURY [Faint text]</p>	
<p>19. SIGNATURE OF JURY [Faint text]</p>		<p>20. SIGNATURE OF JURY [Faint text]</p>		<p>21. SIGNATURE OF JURY [Faint text]</p>	
<p>22. SIGNATURE OF JURY [Faint text]</p>		<p>23. SIGNATURE OF JURY [Faint text]</p>		<p>24. SIGNATURE OF JURY [Faint text]</p>	
<p>25. SIGNATURE OF JURY [Faint text]</p>		<p>26. SIGNATURE OF JURY [Faint text]</p>		<p>27. SIGNATURE OF JURY [Faint text]</p>	
<p>28. SIGNATURE OF JURY [Faint text]</p>		<p>29. SIGNATURE OF JURY [Faint text]</p>		<p>30. SIGNATURE OF JURY [Faint text]</p>	
<p>31. SIGNATURE OF JURY [Faint text]</p>		<p>32. SIGNATURE OF JURY [Faint text]</p>		<p>33. SIGNATURE OF JURY [Faint text]</p>	
<p>34. SIGNATURE OF JURY [Faint text]</p>		<p>35. SIGNATURE OF JURY [Faint text]</p>		<p>36. SIGNATURE OF JURY [Faint text]</p>	
<p>37. SIGNATURE OF JURY [Faint text]</p>		<p>38. SIGNATURE OF JURY [Faint text]</p>		<p>39. SIGNATURE OF JURY [Faint text]</p>	
<p>40. SIGNATURE OF JURY [Faint text]</p>		<p>41. SIGNATURE OF JURY [Faint text]</p>		<p>42. SIGNATURE OF JURY [Faint text]</p>	
<p>43. SIGNATURE OF JURY [Faint text]</p>		<p>44. SIGNATURE OF JURY [Faint text]</p>		<p>45. SIGNATURE OF JURY [Faint text]</p>	
<p>46. SIGNATURE OF JURY [Faint text]</p>		<p>47. SIGNATURE OF JURY [Faint text]</p>		<p>48. SIGNATURE OF JURY [Faint text]</p>	
<p>49. SIGNATURE OF JURY [Faint text]</p>		<p>50. SIGNATURE OF JURY [Faint text]</p>		<p>51. SIGNATURE OF JURY [Faint text]</p>	
<p>52. SIGNATURE OF JURY [Faint text]</p>		<p>53. SIGNATURE OF JURY [Faint text]</p>		<p>54. SIGNATURE OF JURY [Faint text]</p>	
<p>55. SIGNATURE OF JURY [Faint text]</p>		<p>56. SIGNATURE OF JURY [Faint text]</p>		<p>57. SIGNATURE OF JURY [Faint text]</p>	
<p>58. SIGNATURE OF JURY [Faint text]</p>		<p>59. SIGNATURE OF JURY [Faint text]</p>		<p>60. SIGNATURE OF JURY [Faint text]</p>	
<p>61. SIGNATURE OF JURY [Faint text]</p>		<p>62. SIGNATURE OF JURY [Faint text]</p>		<p>63. SIGNATURE OF JURY [Faint text]</p>	
<p>64. SIGNATURE OF JURY [Faint text]</p>		<p>65. SIGNATURE OF JURY [Faint text]</p>		<p>66. SIGNATURE OF JURY [Faint text]</p>	
<p>67. SIGNATURE OF JURY [Faint text]</p>		<p>68. SIGNATURE OF JURY [Faint text]</p>		<p>69. SIGNATURE OF JURY [Faint text]</p>	
<p>70. SIGNATURE OF JURY [Faint text]</p>		<p>71. SIGNATURE OF JURY [Faint text]</p>		<p>72. SIGNATURE OF JURY [Faint text]</p>	
<p>73. SIGNATURE OF JURY [Faint text]</p>		<p>74. SIGNATURE OF JURY [Faint text]</p>		<p>75. SIGNATURE OF JURY [Faint text]</p>	
<p>76. SIGNATURE OF JURY [Faint text]</p>		<p>77. SIGNATURE OF JURY [Faint text]</p>		<p>78. SIGNATURE OF JURY [Faint text]</p>	
<p>79. SIGNATURE OF JURY [Faint text]</p>		<p>80. SIGNATURE OF JURY [Faint text]</p>		<p>81. SIGNATURE OF JURY [Faint text]</p>	
<p>82. SIGNATURE OF JURY [Faint text]</p>		<p>83. SIGNATURE OF JURY [Faint text]</p>		<p>84. SIGNATURE OF JURY [Faint text]</p>	
<p>85. SIGNATURE OF JURY [Faint text]</p>		<p>86. SIGNATURE OF JURY [Faint text]</p>		<p>87. SIGNATURE OF JURY [Faint text]</p>	
<p>88. SIGNATURE OF JURY [Faint text]</p>		<p>89. SIGNATURE OF JURY [Faint text]</p>		<p>90. SIGNATURE OF JURY [Faint text]</p>	
<p>91. SIGNATURE OF JURY [Faint text]</p>		<p>92. SIGNATURE OF JURY [Faint text]</p>		<p>93. SIGNATURE OF JURY [Faint text]</p>	
<p>94. SIGNATURE OF JURY [Faint text]</p>		<p>95. SIGNATURE OF JURY [Faint text]</p>		<p>96. SIGNATURE OF JURY [Faint text]</p>	
<p>97. SIGNATURE OF JURY [Faint text]</p>		<p>98. SIGNATURE OF JURY [Faint text]</p>		<p>99. SIGNATURE OF JURY [Faint text]</p>	
<p>100. SIGNATURE OF JURY [Faint text]</p>		<p>101. SIGNATURE OF JURY [Faint text]</p>		<p>102. SIGNATURE OF JURY [Faint text]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9512

09428

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>68 E. Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weland Memorial</u>		d. STREET ADDRESS <u>15600 Nicholson St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Perry W. Browning</u>		4. DATE OF DEATH Month Day Year <u>Aug. 28 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-78</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>coffee merchant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore F. Browning</u>		14. MOTHER'S MAIDEN NAME <u>Ella Maddox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerotic degeneration</u> DUE TO <u>general arterio sclerosis</u> (c) <u>undetermined</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>1 day</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 16</u> , 19 <u>60</u> , to <u>Aug 28</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug 26</u> , 19 <u>60</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>L W Melin</u>		22b. DATE SIGNED <u>8-28-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>L W Melin MD</u>		22d. ADDRESS <u>Riverdale Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/1/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
25a. REC'D <u>REG 31 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	

1938

CERTIFICATE OF DEATH

DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
9532
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09429
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) T.B. Brandywine		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Brandywine	
NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brandywine-Waldorf, Med. Clinic		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Joseph Middle Anthony Last Burton		4. DATE OF DEATH August 2, 1960	
5. SEX M.	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Lee Burton		14. MOTHER'S MAIDEN NAME Mary Tharston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 223-18-5707	
17. INFORMANT Mrs. Jane M. Burton		Address Brandywine Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 / myocentral infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Remedy Card used and Alkermes (c) Oxy Broc PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 hr INTERVAL BETWEEN ONSET AND DEATH years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-10, 1960, to 8-2, 1960, that I last saw the deceased alive on 8-2, 1960, and that death occurred at 7:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Arthur S. Dobson M.D.		Brandywine Md	
PHYSICIAN'S NAME (Type) Reck & J. H. Dobson		Brandywine Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1960	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Hunter Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE AUG 10 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

Have Female Home, Wadsworth, Md.
Garrison Had. 21st National Assn. of Women, Virginia

Ms. Wm. 1 33318-202

Robert Lee Burton

Chemist

M. White

X
Wadsworth

April 22 1898 P.S.

Virginia

Mary Thornton

Mrs. Jane M. Burton,
Md.

Wadsworth

N. 2 A

August 2,

Brandwine

Wadsworth

Prince George

Brandwine-Wadsworth, Wadsworth, Md.

T.B. Brandwine

Prince George

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9458

09430

1. PLACE OF DEATH a. COUNTY P rince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 day		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 1 4211 28th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle T Last Cade			4. DATE OF DEATH Month Aug. Day 11 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 Mar 1881		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY C&O R.R.		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME improvement				14. MOTHER'S MAIDEN NAME improvement			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Ethel L. Buff Address 4211 28th St. Mt. Rainier, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 8 19 60 , to Aug. 11 19 60 , that (I) (we) last saw the deceased alive on Aug. 11 19 60 , and that death occurred at 5:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE William D. Rossin M.D.				22b. DATE SIGNED Aug 11, 1960		22c. PHYSICIAN'S NAME (Type) Dr. Willian D. Rossin, M.D.	
22d. ADDRESS 5304 ANNAPOLIS RD, Bladensburg MD.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 13, 1960		23c. NAME OF CEMETERY OR CREMATORY H. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Bladensburg Md	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 5201 Cleveland Ave				25a. REC'D BY REGISTRAR DATE AUG 18 '60		25b. REGISTRAR'S SIGNATURE C. L. K. K.	

8458

CERTIFICATE OF DEATH

8458

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9533

CERTIFICATE OF DEATH

Reg. Dist. No.

03431

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 2 BOX 6</u>				d. STREET ADDRESS <u>1 RT 2 BOX 6</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOVITA CARLYN. CARRICO</u>				4. DATE OF DEATH Month Day Year <u>AUG. 16 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11 1904</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CRISFIELD, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm Jerome Sterling</u>				14. MOTHER'S MAIDEN NAME <u>Lavina Sterling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-16-5499</u>		17. INFORMANT Address <u>Robert M. Carrico</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED CARCINOMATOSIS</u> 3 YRS. (c) <u>CARCINOMA OF OVARY</u> 4 YRS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RHEUMATIC HEART DISEASE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. t. p. m. <u>None</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>AUG 6, 1960</u> , to <u>Present</u> , that I last saw the deceased alive on <u>AUG 12, 1960</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Branch Ave - Clinton Md.</u> DATE SIGNED <u>8/16/60</u>							
ACTUAL SIGNATURE <u>Arthur Shaver Jr. M.D.</u>				PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. BRANCH AVE. - CLINTON MD. 8/16/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 18 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Bros</u> ADDRESS <u>1661-94 Hopedale</u>				24a. REC'D BY REGISTRAR <u>AUG 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Colman S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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CRISFIELD, MD.

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571-16-844 Robert M. Carrico
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John

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J. Shaw

S. SHAW

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9459

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09432

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> 1560-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges General Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>SUSANNA</i> Middle <i>B.</i> Last <i>Chamberlain</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>30</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 21, 1883</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>7</i> Hours <i>7</i> Min. <i>7</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>JOAB E. JACKSON</i>		14. MOTHER'S MAIDEN NAME <i>Robert B. Burwell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Grace Shadden</i>		Address <i>5521 47th av Burrdale, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple pulmonary emboli</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>marked patchy atelectasis</i> (c) <i>generalized arterio sclerotic heart disease</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>left trochanteric fracture</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <i>3</i> Hour <i>o. m.</i> <i>8-19</i> 19 <i>60</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dayton Watkins</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>DAYTON OWATKINS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>Sept 3, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>GLENWOOD</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers Co. Burrdale, Md</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 2 '60</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knead</i>	

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FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES'S MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES'S					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale D.C.A.						c. LENGTH OF STAY IN 1b MT. RAINIER 48					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) LELAND MEMORIAL HOSPITAL						d. STREET ADDRESS 3370 CHILLUM RD 1					
3. NAME OF DECEASED (Type or print) FELIX PREZIOSI CIANCARUSO						4. DATE OF DEATH Month Day Year AUG 5 1960					
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 29, 1897 63 yrs.		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN				10b. KIND OF BUSINESS OR INDUSTRY UNIV. MARYLAND				11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ALEXANDER CIANCARUSO						14. MOTHER'S MAIDEN NAME ADELE PREZIOSI					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 052-05-4834		17. INFORMANT ALBERT D. MINICHELLA Address 2703 ARUNDEL RD MT. RAINIER, MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) L442X DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8-6-60 Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Aug 8, 1960 22c. NAME OF CEMETERY OR INTERMENT George Washington 22d. LOCATION (City, town, or country) (State) Hyattsville, Md. 23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. 24a. REC'D BY REGISTRAR DATE AUG 9 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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9534

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN b. 4		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5608 Queens Chapel Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary E. Clancy		4. DATE OF DEATH 8-21-1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12, 1874	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas Murphy		14. MOTHER'S MAIDEN NAME Margaret Walsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		INFORMANT Anna M. Clancy, Daughter Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO 10 yrs. (c) Arteriosclerosis DUE TO 20 yrs.					INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Dec 20, 1955, to 20 Aug. 1960, that I last saw the deceased alive on 20 August 1960, and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis T. Coleman		M.D. 5315 - 16th St. N.W.		DATE SIGNED 21 Aug. '60	
PHYSICIAN'S NAME (Type) Francis T. Coleman M.D.		Wash D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
22d. LOCATION (City, town, or county) Washington, D.C.		22e. ADDRESS Mt. Rainier Md.		24a. REC'D BY REGISTRAR DATE AUG 29 '60	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home Inc.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to contain details about a death certificate, including names, dates, and locations.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>	
c. LENGTH OF STAY IN 1b <u>1 hour</u>		d. STREET ADDRESS <u>17219 - Central Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wesberah Coffey</u>		4. DATE OF DEATH <u>Aug 1 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Ray Coffey</u>		14. MOTHER'S MAIDEN NAME <u>Phyllis Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Henry R Coffey, same as #2</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>830X Hemorrhage and shock</u> Conditions, if any, which gave rise to immediate cause (b) <u>Rupture of the liver</u> (e), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Run over by a truck</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:45 p.m. 8-1 1960</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>yard of home</u>		20f. (City or town) <u>Seat Pleasant P.S. Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-5-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Church Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Chesterfield, N. Car</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale, Md</u>		24a. REC'D BY REGISTRAR <u>Aug 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>		DATE <u>AUG 4 '60</u>	

100-15

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[Faint, mostly illegible handwritten text, possibly a medical report or letter, covering the majority of the page.]

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

9461

10577

1. PLACE OF DEATH a. COUNTY <i>Prince Geo's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges General</i>		d. STREET ADDRESS <i>Box XXXXXXX 4273</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>WALTER OTTO COOKE</i>		4. DATE OF DEATH <i>July 25</i> 19 <i>60</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1884</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, <i>Retired Specialist</i>)		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>FRANK L COOKE</i>		14. MOTHER'S MAIDEN NAME <i>Sara Parker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Frances Cook</i>		Address same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> 442X DUE TO <i>Cardiovascular Renal Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> (c) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>none</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dayton O Watkins</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>8/25/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/29/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ritchie Bros.</i>		ADDRESS <i>Upper Marlboro, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>SEP 21 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

9535

CERTIFICATE OF DEATH

09436
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN lb <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>30 Md Hospital Center</u>				d. STREET ADDRESS <u>Rt #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Zeta</u> First <u>Cora</u> Middle <u>Cutler</u> Last				4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 13, 1903</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David M. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Frances Caroline Fish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>W. M. Cutler</u> Address <u>Husband Rt #1 Brandywine, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>with severe CHF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Thrombophlebitis, R/L & Pelvis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 23</u> , 19 <u>60</u> , to <u>Aug 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug 24</u> , 19 <u>60</u> , and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vivian Chang</u> M.D.				ADDRESS (Street, city or town, state) <u>c/o Southern Maryland Hospital</u>		DATE SIGNED <u>8-24-60</u>	
PHYSICIAN'S NAME (Type) <u>Vivian Chang</u>				<u>Clinton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel</u>		22d. LOCATION (City, town, or county) (State) <u>Badon, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF TEXAS

7530

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G270 9-6-60 et

9462

CERTIFICATE OF DEATH

Reg. Dist. No. 09437

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Esther First Q Middle Davis Last		4. DATE OF DEATH Month Aug Day 29 Year 19 60	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/25
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 34 Days 25	11. IF UNDER 24 HRS. Hours 34 Min. 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Burlington, N. C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Jefferies		14. MOTHER'S MAIDEN NAME Zula Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Chapel Oaks, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the cervix DUE TO metastases & anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 171X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sept 1959 - 8-29-60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 24 , 19 60 , to Aug 29 , 19 60 , that I last saw the deceased alive on August 29 , 19 60 , and that death occurred at 9:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jorge Labarraque		ADDRESS (Street, city or town, state) 1723 M St NW Wash D.C.	
PHYSICIAN'S NAME (Type) JORGE LABARRAQUE		DATE SIGNED Aug 31 '60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Shipped		22b. DATE THEREOF 9-1-1960	
22c. NAME OF CEMETERY OR CREMATORY Martin Chapel Church		22d. LOCATION (City, town, or county) (State) Burlington, N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Malvont Schey Inc		24a. REC'D BY REGISTRAR 424 R St NW DC	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline		DATE AUG 31 '60	

3462



James George
University
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Capital Hill
2000 Address Chapel St

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of the certificate is not filled out, the entire certificate should be void. The Medical Examiner's Office along with form PM3, Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9463

09438

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b Dead on arrival Cheverly		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 3129 Parkway		
3. NAME OF DECEASED (Type or print) Thomas Eugene Day			4. DATE OF DEATH August 20, 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1921		9. AGE (in years last birthday) 38 yrs. 38 Months 38 Days 38 Hours 38 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician			10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Wallace E. Day		
14. MOTHER'S MAIDEN NAME Mary E. King			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		
16. SOCIAL SECURITY NO. WW II			17. INFORMANT Mary S. Day, Same as # 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (b) Subacute bacterial endocarditis (a), stating the underlying cause last. DUE TO (c) Rheumatic heart disease					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/20/60	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/60		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
22d. LOCATION (City, town, or country) Wheaton Md.		23. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.			
24a. REC'D BY REGISTRAR AUG 25 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

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THE STATE
DEPARTMENT



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Prince George's
Chesley
Lead on arrival Chesley
Prince George's General Hospital 1129 Parkway
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Thomas
Mary E. King
Sept. 21, 1951
xx

Electrocardiogram
Wallace E. Day
Mary E. King
U. S. A.
Yes
WW II
Mary E. Day, same as S

Acute congestive heart failure
Rheumatic heart disease
xx

James I. Day
3/20/50
xx

James I. Day
3/20/50
xx

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09439

9536

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS (RURAL)</u>				c. LENGTH OF STAY IN b. <u>5 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USA Hospital Andrews</u>				d. STREET ADDRESS <u>117 Iroquois Way</u>			
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>D</u> Last <u>Denison</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 24, 1904</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James D Denison</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Fowler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Son Dwight Denison</u> Address <u>117 Prigonsky</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF LUNG</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>21 August, 1960</u> , to <u>21 Aug., 1960</u> , that I last saw the deceased alive on <u>21 August, 1960</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u> </u> <u>21 AUGUST 1960</u>							
ACTUAL SIGNATURE <u>Jerome Tilles</u>				M.D. <u>USAF HOSPITAL ANDREWS</u>			
PHYSICIAN'S NAME (Type) <u>JEROME TILLES, CAPT, USAF MC S</u>				<u>ANDREWS AFB WASHINGTON 25, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Star Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Proton Conn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lemmons Bros.</u> ADDRESS <u>1661 Good Hope Rd SE WASH 20525</u>				24a. REC'D BY REGISTRAR <u>AUG 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

9537

Items 4, 21 Film G271 9-15-60 et

CERTIFICATE OF DEATH

09440

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS 4804 Roblee Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marybeth First DeSantis Middle Last 4. DATE OF DEATH Month August Day 21 Year 60 19				5. SEX Female 6. COLOR OR RACE Caucasion 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH 21 July 1960 8. AGE (In years last birthday) yrs. 1 IF UNDER 1 YEAR Months Days Hours Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) District Columbia 12. CITIZEN OF WHAT COUNTRY? United States				3. FATHER'S NAME Frank DeSantis 14. MOTHER'S MAIDEN NAME Barbara A. DeSantis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. N/A INFORMANT Frank J. DeSantis Address 4804 Roblee Drive, Upper Marlboro, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown, DOA 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brought to USAF Hospital Andrews (DOA) by Emergency Rescue Squad 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Unknown Hour a.m. Aug 20 19 60 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Upper Marlboro (PG) Md.				21. I certify that I attended the deceased from 0845 hrs , 19 60 to 0845 , 19 60 , that I lost saw the deceased alive on N/A , 19 60 , and that death occurred at N/A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF Hosp., Andrews 8/21/60 DATE SIGNED James W. G. Carman M.D. ACTUAL SIGNATURE James W. G. Carman, M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 8/24/60 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer, Va. 22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.				23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home- 24a. REC'D BY REGISTRAR AUG 23 '60 24b. REGISTRAR'S SIGNATURE Charles S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT
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TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09441

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Rainier			c. LENGTH OF STAY IN 1b Adelphi			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3523 37th Street			d. STREET ADDRESS 2215 University Boulevard			
3. NAME OF DECEASED (Type or print) HOWARD			4. DATE OF DEATH August 12, 1960.			
5. SEX Male			6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH December 30 1893 64			
9. AGE (In years last birthday) 66 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY Printing			
11. BIRTHPLACE (State or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALVA DRAKE <i>unknown</i>			14. MOTHER'S MAIDEN NAME ELMOINA BENEWAY <i>unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO. 140-14-7789			
17. INFORMANT Arthur H. D. Williams			Address 5822 Greenlawn Dr. Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of the heart DUE TO (c) Cardiovascular renal disease						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic valvular disease- rheumatic						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
Address (Street, city, town, or county) August 12, 1960.						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-16-1960		22c. NAME OF CEMETERY OR CREMATORY Highlands Mill		
22d. LOCATION (City, town, or country) (State)		Highlands, New York				
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.			24a. REC'D BY REGISTRAR Aug 18 '60			
24b. REGISTRAR'S SIGNATURE <i>Arthur H. D. Williams</i>						

FOR RENT
HEAVY DUTY
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Prince George County

Maryland

Prince George

Mount Rainier

Abolition

3523 7th Street

3215 University Boulevard

HOWARD

BRANK

August 12, 1960

Male White

December 10, 1923

Medicist

Printing

New York

U.S.A.
ELMIRA PENNSYLVANIA

140-1-7789 Arthur W. D. Williams

1922
Petersburg, Md.

Cardiac Tumor

Rupture of the heart

Cardiovascular renal disease

Aortic valve disease - rheumatic

xxx

JAMES I. BOYD, M.D.

August 12, 1960

V. V. CHAMBERS CO., Riverdale, Md.

Mt. 1-60

04415

CERTIFICATE OF DEATH

9538

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State of Washington
County of King
I, the undersigned, being a duly qualified medical examiner, do hereby certify that on the 1st day of January, 1914, at the City of Seattle, in the County of King, State of Washington, I examined the body of one [Name], who had died at the residence of the deceased, and found that the same had died of [Cause of Death].
Witness my hand and the seal of my office this 1st day of January, 1914.
[Signature]
Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY P. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base		c. LENGTH OF STAY IN 1b 53 MIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP Andrews, Wash 25, DC		d. STREET ADDRESS 3302 BOONES LANE,	
3. NAME OF DECEASED (Type or print) First NEWBORN Middle ENNIS Last ENNIS		4. DATE OF DEATH Month 8 Day 25 Year 1960	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Aug. 60
9. AGE (In years last birthday) NB		10. IF UNDER 1 YEAR Months Newborn Days 0 Hours 0 Min 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME ENNIS, ERNEST A.		14. MOTHER'S MAIDEN NAME RITTUE, VALORIE J.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA (If yes, give war or dates of service) NA		16. SOCIAL SECURITY NO. NA	
INFORMANT ERNEST A ENNIS (FATHER)		Address SAME AS #2	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Calcification 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Prematurity DUE TO (c) 53 MIN		INTERVAL BETWEEN ONSET AND DEATH 53 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 August, 1960 , to 25 August, 1960 that I lost saw the deceased alive on 25 August, 1960 , and that death occurred at 1:28 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James M Finneran		DATE SIGNED USAF HOSP ANDREWSN 25 AUGUST 1960	
PHYSICIAN'S NAME (Type) JAMES M FINNERAN, CAPT USAF MC		USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-30-60	
22c. NAME OF CEMETERY OR CREMATORY D. C. Morgue		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 31 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Finneran	

10418

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

WASHINGTON, D.C.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09444

1. PLACE OF DEATH a. COUNTY Prince Geo Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE md b. COUNTY Pr Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b Pr Geo Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo General Hospital		e. STREET ADDRESS 3716-43 ave 1	
3. NAME OF DECEASED (Type or print) HENRY EPSTEIN		4. DATE OF DEATH Aug 21 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-20 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY arcade	
11. BIRTHPLACE (State or foreign country) Baltimore md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS EPSTEIN		14. MOTHER'S MAIDEN NAME MARY LIPSTITZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578057142	
17. INFORMANT Leonora Resnick		Address 3716-43 ave 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Arteriosclerotic Cardiovascular Dis 4m Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) asthma 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON OWATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-21-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-23-60	
22c. NAME OF CEMETERY OR CREMATORY Herring Run		22d. LOCATION (City, town, or county) (State) Balto md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		ADDRESS 2100 Eutan Place	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE AUG 23 '60		C. H. H. H.	

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Barry (A)

Female Colonel

Female from

(1)

Barry from

Dr. Thomas A. Greenman, 1000 Soldiers Ave.

College Ave.

Handwritten signatures and notes at the bottom of the page.

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9466

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

See: Birth Cert. **CERTIFICATE OF DEATH**

09446

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pri. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 hrs 15 Min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS 908 Addison-Chappel Road			
3. NAME OF DECEASED (Type or print) First Baby Girl (B) Middle Everett Last Everett				4. DATE OF DEATH Month August Day 6 Year 19 60			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-6-60	
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 15		IF UNDER 24 HRS. Hours 3 Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cheverly, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Donald Brown				14. MOTHER'S MAIDEN NAME Doris Everett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Pneumonia (avoidable one breath) DUE TO (b) Asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 6 19 60 to Aug. 6 19 60 that (I) (we) last saw the deceased alive on Aug. 6 19 60 and that death occurred at 7 PM , from the causes and on the date stated above.							
22a. SIGNATURE Thomas A. Christensen M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr Thomas A. Christensen M.D.				22d. ADDRESS 6905 Baltimore Ave. College Park Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 8/19/1960			
23c. NAME OF CEMETERY OR CREMATORY Prince Georges Cemetery				23d. LOCATION (City, town, or county) (State) Cheverly Md			
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Brown ADDRESS Adams				25a. REC'D BY REGISTRAR Aug 22 1960 DATE			
				25b. REGISTRAR'S SIGNATURE Carl S. Hanna			

0486

CERTIFICATE OF DEATH

00410

1

DATE OF BIRTH

PLACE OF BIRTH

NOT TO BE

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LANHAM c. LENGTH OF STAY IN 1b 04 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PRESLEY RD. RT. 1.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LANHAM d. STREET ADDRESS 312 PRESLEY RD RT. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM BOWYER FITZGERALD				4. DATE OF DEATH Month Day Year AUG 7 1960			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 30, 1907	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROUND MAN				10b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL CONST.		11. BIRTHPLACE (State or foreign country) VIRGINIA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME WILLIAM H. FITZGERALD				14. MOTHER'S MAIDEN NAME MARY E. COFFEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WORLD WAR 2				16. SOCIAL SECURITY NO. 231-05-5772		17. INFORMANT HALSEY C. FITZGERALD Address SAME AS #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) gunshot wound of chest DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) shot with shot gun			
20c. TIME OF INJURY Hour a.m. p.m. 1:15 8-6-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In wooded area Lanham P.S.		20f. (City or town) (County) (State) Lanham P.S. Prince Georges Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. BOYD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 8-9-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-11-1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
				22d. LOCATION (City, town, or country) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR W.W. Chambers & Son				ADDRESS Rivindale Md			
				24a. REC'D BY REGISTRAR DATE AUG 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MEDICAL CERTIFICATION

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UNITED STATES DEPARTMENT OF JUSTICE

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9467

CERTIFICATE OF DEATH

09448

Reg. Dist. No:

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b 26 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2604 Cheverly avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Raymond Last Fletcher		4. DATE OF DEATH Month August Day 27 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1900
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Judge		10c. KIND OF BUSINESS OR INDUSTRY Prince George's Co	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Langdon Fletcher		14. MOTHER'S MAIDEN NAME Grace Etta Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Emma L Fletcher		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Pneumonia DUE TO (c) Cerebral Thrombosis & Left Hemiplegia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 60 , to Aug 27 , 19 60 , that I last saw the deceased alive on Aug 27 , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis M. Jimal		ADDRESS (Street, city or town, state) 4008 Bladensburg Rd., Cottage City, Md.	
PHYSICIAN'S NAME (Type) Louis M. Jimal M. D.		DATE SIGNED 8/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 30, 1960	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR AUG 31 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hance	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09450

9469

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastpines			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frieda Hedwig Franke				4. DATE OF DEATH Month Day Year August 30, 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1872	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? Germany							
13. FATHER'S NAME Truettott Woohlgemut				14. MOTHER'S MAIDEN NAME Augusta Frommhold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. None		17. INFORMANT Max Franke (Husband) Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident DUE TO (b) Generalized arteriosclerosis (c) Cerebral Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE Dayton Watkins M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DAYTON WATKINS ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/1/60 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 9/3/60 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md. 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland 24a. REC'D BY REGISTRAR DATE SEP 6 '60 24b. REGISTRAR'S SIGNATURE William S. Thomas							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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09451

Reg. Dist. No.

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)
ISM 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF BIRTH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4903 Ravenswood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel Adel Freeland		4. DATE OF DEATH Month August Day 22, Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gift Shop	11. BIRTHPLACE (State or foreign country) South Dekota
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME George W Freeland	
14. MOTHER'S MAIDEN NAME Hattie Sebbins		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. no		INFORMANT Address Isabel Freeland Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident 420-9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4 , 19 40 , to 8-21 , 19 60 that I last saw the deceased alive on 8-20 , 19 60 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville Md DATE SIGNED 8/22/60 ACTUAL SIGNATURE AA Deitz M.D. Hyattsville Md PHYSICIAN'S NAME (Type) AA Deitz Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/60	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE AUG 26 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Kraus	

CERTIFICATE OF DEATH

1913

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Place of Birth

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Riverdale, Ill.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09452

9470

1. PLACE OF DEATH a. COUNTY <u>PR GEO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PR GEO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. LENGTH OF STAY IN 1b <u>DoA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3104 Shepherd St. 47</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PRINCE Geo General</u>				d. STREET ADDRESS <u>Mt. Rainier, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RALPH WYLLIE FREY</u>				4. DATE OF DEATH Month Day Year <u>AUG 22 19 60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 28 1889</u>		9. AGE (In years last birthday) <u>71</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LOUIS A. FREY</u>				14. MOTHER'S MAIDEN NAME <u>FLORIDA V WYLLIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-40-6333</u>		17. INFORMANT <u>HYATT WYLLIE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cordis Vasculum</u> DUE TO (c) <u>dissecting</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home, Inc.</u>				ADDRESS <u>Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 29 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE SIGNED <u>8-22-60</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9541

09453

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 625 K. St., S. E.			
3. NAME OF DECEASED (Type or print) First Mary Middle - Last Green				4. DATE OF DEATH Month 8 Day 17 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/25/1853?	
9. AGE (In years last birthday) 106?		IF UNDER 1 YEAR Months - Days -		IF UNDER 24 HRS. Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Muriel Marshall	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Phlebothrombosis, left leg, amputation stump DUE TO (c) Septic gangrene, left leg				INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week unk.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D. C.				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/26/60 to 8/17/60 , that (I) (we) last saw the deceased alive on 8/17/60 , and that death occurred at P. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 8/17/60		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.	
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Removal		8/19/60		116455 AVE N.W.		Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Joyner				25a. REC'D BY REGISTRAR Aug 22 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

00173

CHINESE OF DEATH

0541

14

1

RECEIVED

100 WILCOX

Removal 8/18/60
Henry C. Rogers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9542

CERTIFICATE OF DEATH

Reg. Dist. No. 08454

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oak Inn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1403 - 57th Place		d. STREET ADDRESS 4319 - Anacostia Ave. N.E.	
3. NAME OF DECEASED (Type or print) Chauncey Grimes		4. DATE OF DEATH Aug. 30 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Guard		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Va.	
11. BIRTHPLACE (State or foreign country) U.S. A.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Heeling Grimes		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 210	
17. INFORMANT Address Martha E. Grimes 4319 Anacostia Ave. N.E.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Left Ventricular Heart Failure (b) Hypertensive Cardiovascular Disease (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Partial Paralysis - Arthritis Deformans (Generalized) INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 30, 1960, to Aug. 30, 1960, that I last saw the deceased alive on Aug. 28, 1960, and that death occurred at 5:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Robinson, M.D.		ADDRESS (Street, city or town, state) Washington 27, D.C.	
PHYSICIAN'S NAME (Type) 1001 Eastern Ave. N.E.		DATE SIGNED 8/30/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 3, 1960	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem		22d. LOCATION (City, town, or county) (State) 4600 Ben. Rd N.E. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Campbell		ADDRESS 442 M St NW	
24a. REC'D BY REGISTRAR DATE SEP 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE DEPARTMENT OF HEALTH - BOSTON
CERTIFICATE OF DEATH

1. Name of deceased: *John W. Robinson*
2. Age: *45*
3. Sex: *Male*
4. Race: *White*
5. Date of death: *Jan. 20, 1900*
6. Place of death: *Home*
7. Cause of death: *Heart disease*
8. Signature of physician: *John W. Robinson*
9. Signature of registrar: *John W. Robinson*
10. Date of registration: *Jan. 20, 1900*

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9471 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09455

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverley		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Hillside		d. STREET ADDRESS 1204 48th Ave	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges' Gen Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Raymond		First Valentine Middle GRIMES Last		4. DATE OF DEATH Aug 18 19 60		Month Aug Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1882	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 78 Days	IF UNDER 24 HRS. Hours 78 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardiner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard F. Grimes				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Ruth Grimes		Address same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>		EXAMINER'S NAME (Type) James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED August 18, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md				24a. REC'D BY REGISTRAR DATE AUG 19 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

MEDICAL CERTIFICATION

DO NOT WRITE IN THESE SPACES



Male White
 Prince Georges, Gen Hospital
 1504 North Ave
 D.O.A.
 H. J. White
 Prince Georges
 Maryland
 Prince Georges

Richard F. Grimes
 U.S. Navy
 District of Columbia
 Unknown
 Unknown
 None
 Mrs Ruth Grimes
 same as # 2
 Cardio-vascular renal disease
 Acute congestive heart failure

James I. Boyd
 August 15, 1960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9543

CERTIFICATE OF DEATH

09456
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hill, Maryland c. LENGTH OF STAY IN 1b 25 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5400- Fisher Road S.E.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's. Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hill, Maryland d. STREET ADDRESS 5400- Fisher Road S.E. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First E. Middle HABEEB Last		4. DATE OF DEATH Month August Day 28th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1st March 1870
9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) El-Knessie, Lebanon.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ayout Asmar		14. MOTHER'S MAIDEN NAME Frusina Haber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Naseef E. Habeeb, Same as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Arterio sclerotic cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. old age DUE TO old age		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 8 , 1960, to Aug 28 , 1960, that I last saw the deceased alive on Aug 28 (7 AM) , 1960, and that death occurred at 8:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2-Parkway Drive Forest Heights, Md. 8/28/60 DATE SIGNED ACTUAL SIGNATURE D. Pierre Gollon M.D. PHYSICIAN'S NAME (Type) Etienne Szollosi 2-Parkway Drive Forest Heights, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31st. 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers ADDRESS 1661- Good Hope Rd. SE Washington, D.C.		24a. REC'D BY REGISTRAR DATE AUG 30 '60	
		24b. REGISTRAR'S SIGNATURE William S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9515

CERTIFICATE OF DEATH

09457

Item 8 Film 0271 9-19-60 et

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENTLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LELAND MEMORIAL HOSPITAL		d. STREET ADDRESS 1 7584 HAWTHORNE ST	
3. NAME OF DECEASED (Type or print) First Middle Last MARY ELIZABETH HALL		4. DATE OF DEATH Month Day Year August 26 1960	
5. SEX Fe	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/86 1896
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ARTHUR TUCKER		14. MOTHER'S MAIDEN NAME ELIZABETH PEACOCK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis DUE TO arteriosclerotic heart dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to Aug 26 , 19 60 , that (I) (we) last saw the deceased alive on Aug 26 , 19 60 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE LW Malin		22b. DATE SIGNED 8-26-60	
22c. PHYSICIAN'S NAME (Type) LW Malin MD		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/30/60	
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Gasch sons		25a. REC'D BY REGISTRAR Regan Hall	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Travers	
DATE AUG 31 '60			

10452

CERTIFICATE OF DEATH

9515

MARYLAND

THREE GEORGE

RIVERDALE

LELAND MEMORIAL HOSPITAL

1524 HAWTHORNE ST. N.

MARY ELIZABETH HALL

CH/STREET 14

MARYLAND

ACTING TUCKER

HOSPITAL RECORD

Washington, D. C.

of record of

9515

10452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9544

CERTIFICATE OF DEATH

09458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND PRINCE GEORGES				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS (RURAL)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle CONNER Last HAMILTON				4. DATE OF DEATH Month AUGUST Day 24 Year 1960			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 AUGUST 1960	
9. AGE (In years lost birthday) yrs. 11		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN R HAMILTON				14. MOTHER'S MAIDEN NAME DORIS A WILLIAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NA		17. INFORMANT NONE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock, post operative 560.2 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Omphalocele DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 hrs 12 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Aug, 1960 to 24 Aug, 1960 , that I last saw the deceased alive on 24 Aug, 1960 , and that death occurred at 1945 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS DATE SIGNED 24 AUGUST 60							
ACTUAL SIGNATURE John A. Moore				M.D. USAF HOSPITAL ANDREWS			
PHYSICIAN'S NAME (Type) JOHN A MOORE, MAJOR USAF MC				USAF HOSP ANDREWS ANDREWS AFB, WASH 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 29 Aug. 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, Inc. 816 H St., NE, Wash. 2, D. C.				24a. REC'D BY REGISTRAR DATE AUG 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

(M)

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CERTIFICATE OF DEATH

1440

DEPARTMENT OF COMMERCE

RECORDS SECTION

IT WAS ON THE TWENTY-THIRD

DAY OF JULY (1944)

AT THE CITY OF NEW YORK

DEPARTMENT OF COMMERCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9434 Item 1 Film 271 9-15-60 et

9434

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN <u>6 weeks</u>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		d. STREET ADDRESS <u>16904 Beacon Place 1</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3304 KANDER DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>HART; MICHAEL JOHN</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/59</u>	
9. AGE (In years last birthday) <u>60 1/2</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>		
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Philip J. Hart</u>		14. MOTHER'S MAIDEN NAME <u>Jewel Harper</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>		
17. INFORMANT <u>Mrs Jewel Harper Hart</u>		Address <u>6904 Beacon Pl Riverdale, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYDROCEPHALUS</u> DUE TO <u>344-X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>LIFE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GANGRENE, TRY OF RIGHT FOOT</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>18 July</u> , 19 <u>60</u> , to <u>22 August</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>22 August</u> , 19 <u>60</u> , and that death occurred at <u>2:5 A.M.</u> from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>Joseph F. McDonald</u>		M.D. <u>7309 RICES ROAD</u>		
PHYSICIAN'S NAME (Type) <u>JOSEPH F. McDONALD</u>		ADDRESS (Street, city or town, state) <u>HYATTSVILLE, MD</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-24-1960</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAMBERS FUNERAL HOME</u>		ADDRESS <u>Riverdale, Md.</u>		
24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		

90000000X00

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

See Page No.

1. NAME OF DECEASED JOHN		2. SEX M		3. AGE 45		4. DATE OF BIRTH 1898		5. PLACE OF BIRTH MD		6. OCCUPATION None	
7. MARITAL STATUS Married		8. NAME OF SPOUSE JOHN		9. DATE OF MARRIAGE 1920		10. PLACE OF MARRIAGE MD		11. NAME OF DECEASED'S FATHER JOHN		12. NAME OF DECEASED'S MOTHER JOHN	
13. CAUSE OF DEATH Heart Disease		14. PLACE OF DEATH MD		15. DATE OF DEATH 1943		16. TIME OF DEATH 10:00 AM		17. NAME OF PHYSICIAN JOHN		18. NAME OF FUNERAL HOME JOHN	
19. NAME OF DECEASED'S NEXT OF KIN JOHN		20. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		21. CITY OF DECEASED'S NEXT OF KIN JOHN		22. STATE OF DECEASED'S NEXT OF KIN MD		23. NAME OF DECEASED'S NEXT OF KIN JOHN		24. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
25. NAME OF DECEASED'S NEXT OF KIN JOHN		26. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		27. CITY OF DECEASED'S NEXT OF KIN JOHN		28. STATE OF DECEASED'S NEXT OF KIN MD		29. NAME OF DECEASED'S NEXT OF KIN JOHN		30. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
31. NAME OF DECEASED'S NEXT OF KIN JOHN		32. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		33. CITY OF DECEASED'S NEXT OF KIN JOHN		34. STATE OF DECEASED'S NEXT OF KIN MD		35. NAME OF DECEASED'S NEXT OF KIN JOHN		36. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
37. NAME OF DECEASED'S NEXT OF KIN JOHN		38. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		39. CITY OF DECEASED'S NEXT OF KIN JOHN		40. STATE OF DECEASED'S NEXT OF KIN MD		41. NAME OF DECEASED'S NEXT OF KIN JOHN		42. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
43. NAME OF DECEASED'S NEXT OF KIN JOHN		44. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		45. CITY OF DECEASED'S NEXT OF KIN JOHN		46. STATE OF DECEASED'S NEXT OF KIN MD		47. NAME OF DECEASED'S NEXT OF KIN JOHN		48. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
49. NAME OF DECEASED'S NEXT OF KIN JOHN		50. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		51. CITY OF DECEASED'S NEXT OF KIN JOHN		52. STATE OF DECEASED'S NEXT OF KIN MD		53. NAME OF DECEASED'S NEXT OF KIN JOHN		54. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
55. NAME OF DECEASED'S NEXT OF KIN JOHN		56. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		57. CITY OF DECEASED'S NEXT OF KIN JOHN		58. STATE OF DECEASED'S NEXT OF KIN MD		59. NAME OF DECEASED'S NEXT OF KIN JOHN		60. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
61. NAME OF DECEASED'S NEXT OF KIN JOHN		62. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		63. CITY OF DECEASED'S NEXT OF KIN JOHN		64. STATE OF DECEASED'S NEXT OF KIN MD		65. NAME OF DECEASED'S NEXT OF KIN JOHN		66. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
67. NAME OF DECEASED'S NEXT OF KIN JOHN		68. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		69. CITY OF DECEASED'S NEXT OF KIN JOHN		70. STATE OF DECEASED'S NEXT OF KIN MD		71. NAME OF DECEASED'S NEXT OF KIN JOHN		72. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
73. NAME OF DECEASED'S NEXT OF KIN JOHN		74. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		75. CITY OF DECEASED'S NEXT OF KIN JOHN		76. STATE OF DECEASED'S NEXT OF KIN MD		77. NAME OF DECEASED'S NEXT OF KIN JOHN		78. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
79. NAME OF DECEASED'S NEXT OF KIN JOHN		80. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		81. CITY OF DECEASED'S NEXT OF KIN JOHN		82. STATE OF DECEASED'S NEXT OF KIN MD		83. NAME OF DECEASED'S NEXT OF KIN JOHN		84. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
85. NAME OF DECEASED'S NEXT OF KIN JOHN		86. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		87. CITY OF DECEASED'S NEXT OF KIN JOHN		88. STATE OF DECEASED'S NEXT OF KIN MD		89. NAME OF DECEASED'S NEXT OF KIN JOHN		90. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
91. NAME OF DECEASED'S NEXT OF KIN JOHN		92. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		93. CITY OF DECEASED'S NEXT OF KIN JOHN		94. STATE OF DECEASED'S NEXT OF KIN MD		95. NAME OF DECEASED'S NEXT OF KIN JOHN		96. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	
97. NAME OF DECEASED'S NEXT OF KIN JOHN		98. ADDRESS OF DECEASED'S NEXT OF KIN JOHN		99. CITY OF DECEASED'S NEXT OF KIN JOHN		100. STATE OF DECEASED'S NEXT OF KIN MD		101. NAME OF DECEASED'S NEXT OF KIN JOHN		102. ADDRESS OF DECEASED'S NEXT OF KIN JOHN	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9445

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09460

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pr Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladeensburg		c. LENGTH OF STAY IN 1b POA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHESTER A HENNIGAR		4. DATE OF DEATH August 25 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 5 1905
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Nova Scotia Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Mary (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT JAMES KOHLER		Address 7210 - Hemlock Rd Hyattsville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Wounds Multiple + 810X DUE TO Severe - Amputation of leg Conditions, if any, which gave rise to immediate cause (b) + Am. Disemboweled (c) cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH inst	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject driving a Truck hit by a train	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 8-25 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RR Crossing		20f. (City or town) P.G. (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton D Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON D. WATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-27-60	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		22d. LOCATION (City, town, or county) COTTAGE CITY, MARYLAND (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson		ADDRESS WASH. D.C. 1300 - N ST. N.W.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE AUG 29 '60		C. L. L. L. L.	

8-27-60
FORT WINSTON
COTTAGE CITY, MARYLAND

9545

CERTIFICATE OF DEATH

09461

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden				c. LENGTH OF STAY IN 1b 25 yr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7928 + Lincoln Ave				d. STREET ADDRESS 7928 + Lincoln Ave			
3. NAME OF DECEASED (Type or print) First Middle Last Aphonso Francis Henson				4. DATE OF DEATH Month Day Year Aug. 24 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 19 1934	
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Henson				14. MOTHER'S MAIDEN NAME Bernice C. Henson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. —			
17. INFORMANT Bernice C. Henson				Address Glenarden, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 468.3 DUE TO Pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) @Elephantiasis @Neurofibromatosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 wks 13 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1959, 19 to Aug 1960, that I last saw the deceased alive on Aug 24, 1960, and that death occurred at 11:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Henry A. Wise M.D. Lanham, Md.				8/24/60			
PHYSICIAN'S NAME (Type) Henry A. Wise Jr 9005 Volta St, Lanham, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-27-60		22c. NAME OF CEMETERY OR CREMATORY Mt Albert		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Harry D. Washington 4925 Gleane Ave NE				24a. REC'D BY REGISTRAR DATE AUG 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9435

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09462

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 3+ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8005 14th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Myra J. Herndon		4. DATE OF DEATH Month August Day 19 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1873
9. AGE (In years loss of birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Yowell		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Mamie S. Knott- 8005 14th Avenue Hyattsville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr. 20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 19, 1952 to Aug. 19, 1960 , that (I) (we) last saw the deceased alive on June 9, 1960 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Arthur S. Bresler		22b. DATE SIGNED 8-19-60	
22c. PHYSICIAN'S NAME (Type) Arthur S. Bresler		22d. ADDRESS 533 Riggs Rd., N. E., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8/21/60	
23c. NAME OF CEMETERY OR CREMATORY --		23d. LOCATION (City, town, or county) (State) Standardsville, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Pines Co. - 2901 11th St. N.W. Washington 9, D.C.		25a. REC'D BY REGISTRAR DATE AUG 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

3232

WEST VIRGINIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Hyattsville

6005-12th Avenue

August 29

Hyattsville

Hyattsville

37

June 1, 1907

37

37

37

Hyattsville

Hyattsville

Hyattsville

Hyattsville

1000-12th Avenue

37

37

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9546

09463

1. PLACE OF DEATH e. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glass Manor c. LENGTH OF STAY IN 1b Transient d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 316 Roseld Ct. (In front of)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 829 Quincey St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Leo Francis HINES				4. DATE OF DEATH Month Day Year Aug 18 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Sept 1899	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier		11. BIRTHPLACE (State or foreign country) Maryland W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hines				14. MOTHER'S MAIDEN NAME Margaret E. Stewart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.# 2 578-56-2661		17. INFORMANT Personal Papers			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) carcinosis of liver							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) carcinosis of liver							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/19/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-23-60		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		22d. LOCATION (City, town, or country) (State) Arlington Virginia	
23. FUNERAL DIRECTOR W.W. Chambers Co. 517-11th St S.E.				24a. REC'D BY REGISTRAR AUG 24 '60 24b. REGISTRAR'S SIGNATURE Charles S. Knecht			

MEDICAL CERTIFICATION

00488

MEDICAL EXAMINATION CERTIFICATE OF DEATH

00488

District of Columbia

Prince Georges

Washington

Trinidad

Blaise Honor

510 Nevada St. (In front of) 829 Quincy St.

18

18

WINE

Trinidad

Leo

02

17 Sept 1899

White

Male

U.S.A.

Marjorie K. Van.

Retired

John Hines

Margaret E. Stewart

Yes W.N.R. 2 575-58-2801 Personal Papers

James I. Boyd

James I. Boyd

5419/60

James I. Boyd

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the registrar. Forward the certificate to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9472 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 62/1 9-15-60 et

09464
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pri. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>66 Riverdale</u>	
c. LENGTH OF STAY IN 1b <u>DOH</u>		d. STREET ADDRESS <u>6324 - 61st Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARTIN P</u> Middle <u>Hughes</u> Last <u>Hughes</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 18 1879</u>
9. AGE <u>81</u> yrs. (lay birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired PRINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT Address <u>6324-61st</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident (Cerebral)</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BLOOD VESSEL RUPTURE</u> <u>inst</u> (c) <u>Hypertensive Cardio Vascular disease 5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton Watkins</u>		DATE SIGNED <u>8-31-60</u>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 3, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Chambers</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 2 '60</u>	
ADDRESS <u>66 Riverdale</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

Prince George's
Maryland

Chesley D. O. A. East Port Annapolis

Prince George's General Hospital 325 First Street

Irvin Gordon Harrison August 12, 1960

White July 23, 1918

Painter Dept. Agriculture Virginia U. S. A.

James Hutchinson Ethel Jones

Yes Will 225-22-9274 Mrs Beverly Hutchinson, same as # 2

Hemorrhage and shock

Compound fracture of the skull, fracture of both tibia and fibulae, fracture of right radius and ulna

Fell about 40 feet from a ladder

8/12/60 x Building Baltimore P. O. Md.

8/12/60 x James I. Boyd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9474

09466

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 66 East Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				d. STREET ADDRESS 5603 Longfellow St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby		First Girl		Last Hynson		4. DATE OF DEATH Month Aug Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 August 1960		9. AGE (In years lost birthday) yrs. 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cheverly, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Everett Hynson				14. MOTHER'S MAIDEN NAME Joyce Ann Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) immaturity 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Premature rupture membrane & labor DUE TO (c) Incompetant Cervix						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 15, 1960 to Aug. 15, 1960 , that (I) (we) last saw the deceased alive on Aug. 15, 1960 and that death occurred at 7:15 PM from the causes and on the date stated above.							
22a. SIGNATURE R. Kennedy Skipton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. R. Skipton., M.D.				22d. ADDRESS 4500 College Ave., College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/17/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Cleve Cemetery		23d. LOCATION (City, town, or county) (State) Wash. D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home				ADDRESS 3200 - R. I. Ave		25. REC'D BY REGISTRAR DATE AUG 18 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Perna			

2077201 Inc. XVO

2474

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

1913

IN SENATE,
January 14, 1913.
REPORT
OF THE
ATTORNEY GENERAL
FOR THE YEAR
1912.
ALBANY:
J. B. LIPPINCOTT
PRINTERS,
1913.

TO DEPUTY A
cute
forwarded
TO FUNERAL
or removal.

9547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION	1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's				
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		c. LENGTH OF STAY IN lb transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) On rt. 197 1 1/2 miles no. rt. 50				d. STREET ADDRESS 909 Seventh Street				
	3. NAME OF DECEASED (Type or print) First Middle Last Martin Harrison Innet			4. DATE OF DEATH Month Day Year August 21 1960					
	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1936	9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.		
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
	3. FATHER'S NAME Edward Harrison Innet			14. MOTHER'S MAIDEN NAME Helen Repp					
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. currently		17. INFORMANT Elsie Hagsey Innet		Address same as # 2		
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 979x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Universal charring burns of the body DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH
		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Locked self in burning car					
	20c. TIME OF INJURY Month, Day, Year 9 20 30 a.m. 8 21 60 x.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 197		20f. (City or town) Bowie		(County) P.G.	(State) Md.
	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
	ACTUAL SIGNATURE James I. Boyd				M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/21/60	
	EXAMINER'S NAME (Type) James I. Boyd					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
	22a. BURIAL, CREMATION, REMOVAL (Specify) Removed	22b. DATE THEREOF 8/25/60	22c. NAME OF CEMETERY OR CREMATORY Maker Funeral Home		22d. LOCATION (City, town, or county) (State) Berrington, Vermont				
	23. FUNERAL DIRECTOR'S SIGNATURE Walter S. Wagoner Belair Rd Baltimore - 6 Md				ADDRESS	24a. REC'D BY REGISTRAR DATE AUG 26 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FORM 15 (4)
M 9/59

9516

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09468

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>		c. LENGTH OF STAY IN 1b <u>14 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Mem. Hosp.</u>		e. STREET ADDRESS <u>7207 Garland Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>C.</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>8</u> - Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 9, 1888</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSHUA JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR A. HORNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Patient's Chart</u>		Address <u>Leland Mem. Hosp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>C.S.H.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hr</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-15</u> 19 <u>60</u> to <u>8-31</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>8-30</u> 19 <u>60</u> and that death occurred at <u>230</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Ray B. Brown</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/4/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Church Cem</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
23e. ADDRESS <u>5732</u>		25a. REC'D BY REGISTRAR <u>SEP 2 '60</u>	
23f. FUNERAL DIRECTOR'S SIGNATURE <u>W K HUNTEMANN & SON</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

0040W

CERTIFICATE OF DEATH

2218

X 2218 2218

1918

1918

1918

2218

9548

CERTIFICATE OF DEATH

09469

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS (RURAL)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WASHINGTON 22 DC (RURAL)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews</u>				d. STREET ADDRESS <u>13701 SWAN Harbour Road.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Archie</u> First <u>J.</u> Middle <u>JOHNSON</u> Last				4. DATE OF DEATH <u>August</u> Month <u>29</u> Day <u>1960</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAUC</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 JAN 1923</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USAF</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AIR FORCE PILOT</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Archie Wesley Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Thelma Walbridge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Present</u>				16. SOCIAL SECURITY NO. <u>173-14-5018</u>		17. INFORMANT <u>RECORDS</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myo Cardiac Infarct</u> <u>420.0</u> DUE TO <u>Arterio Sclerotic Heart Disease</u> 3 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EDEMA</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>28 AUGUST</u> , 19 <u>60</u> , to <u>29 AUGUST</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>29 AUGUST</u> , 19 <u>60</u> , and that death occurred at <u>1:47 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>USAF HOSPITAL ANDREWS</u> <u>29 AUGUST 1960</u>							
ACTUAL SIGNATURE <u>Edwin E. Westura</u> M.D.							
PHYSICIAN'S NAME (Type) <u>EDWIN E WESTURA CAPT USAF MC</u>				<u>USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi</u> ADDRESS <u>816 H St., NE, Wash. 2, D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME [Name]		SEX [Male/Female]		DATE OF BIRTH [Date]		PLACE OF BIRTH [Place]	
DECEASED'S RESIDENCE [Address]		DECEASED'S OCCUPATION [Occupation]		DECEASED'S MARITAL STATUS [Single/Married/Divorced/Widowed]		DECEASED'S RACE [Race]	
DECEASED'S RELIGION [Religion]		DECEASED'S EDUCATION [Education]		DECEASED'S SOCIAL SECURITY NUMBER [Number]		DECEASED'S MOTHER'S MAIDEN NAME [Name]	
DECEASED'S FATHER'S NAME [Name]		DECEASED'S MOTHER'S NAME [Name]		DECEASED'S BIRTH ORDER [Order]		DECEASED'S DEATH ORDER [Order]	
DECEASED'S DATE OF DEATH [Date]		DECEASED'S TIME OF DEATH [Time]		DECEASED'S PLACE OF DEATH [Place]		DECEASED'S CAUSE OF DEATH [Cause]	
DECEASED'S MANNER OF DEATH [Manner]		DECEASED'S MEDICAL HISTORY [History]		DECEASED'S PRESENT ILLNESS [Illness]		DECEASED'S TREATMENT [Treatment]	
DECEASED'S SIGNATURE [Signature]		DECEASED'S WITNESS [Witness]		DECEASED'S PHYSICIAN [Physician]		DECEASED'S CORONER [Coroner]	
DECEASED'S COUNTY [County]		DECEASED'S CITY [City]		DECEASED'S STATE [State]		DECEASED'S ZIP CODE [ZIP]	

100-100000

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

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9475

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09470

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 13 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie d. STREET ADDRESS 6501 Darcey Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Johnson		4. DATE OF DEATH Month Day Year Aug. 22 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME George Johnson		14. MOTHER'S MAIDEN NAME Serena Howard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1226 G Street, N.E. D.C.	
17. INFORMANT Maggie Iverson-Sis.		Address 1226 G Street, N.E. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 9 1960 to Aug. 22 1960 , that (I) (we) lost saw the deceased alive on Aug. 22 1960 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE William D. Rosson M.D.		22b. DATE SIGNED 8/23/60	
22c. PHYSICIAN'S NAME (Type) William D. Rosson M.D.		22d. ADDRESS 5304 ANNAPOLIS ROAD BLADENBURG, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/26/60	
23c. NAME OF CEMETERY OR CREMATORY Carroll Chapel		23d. LOCATION (City, town, or county) (State) Mitchellville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John S. Stewart		25a. REC'D BY REGISTRAR DATE AUG 25 '60	
ADDRESS 30 H Street, N.E. D.C.		25b. REGISTRAR'S SIGNATURE John S. Stewart	

9549

CERTIFICATE OF DEATH

09471
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Hghts		c. LENGTH OF STAY IN 1b 13 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Bradbury Hghts			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4809--V--St., S.E.				d. STREET ADDRESS 1 4809--V--St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JUDITH Middle E. Last JOHNSON				4. DATE OF DEATH Month August 6th Day Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1894	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Gustof				14. MOTHER'S MAIDEN NAME Edla K. Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		INFORMANT Address Janet M. Johnson 4809--V-- St., S. E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180x CHRONIC METASTASIS 2° DUE TO (b) ADENO CARCINOMA of KIDNEY DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.							INTERVAL BETWEEN ONSET AND DEATH 4 days 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GACHERIA 2° to 3° & GENERAL METASTASIS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956, to Aug. 6, 1960, that I last saw the deceased alive on 8/6, 1960, and that death occurred at 11:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas F. Cullen M.D. 4400 Bowen Rd., SE Wash. DC 8-7-60							
ACTUAL SIGNATURE Thomas F. Cullen		PHYSICIAN'S NAME (Type) Thomas F. Cullen 4400 Bowen Rd., SE Wash. DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 9, 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 1661--Good Hope Rd., SE Washington 20 DC				24a. REC'D BY REGISTRAR DATE AUG 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

1041

CERTIFICATE OF DEATH

1041

(M)

1. Name of deceased: _____

2. Date of death: _____

3. Place of death: _____

4. Cause of death: _____

5. Name of physician: _____

6. Name of funeral director: _____

7. Name of next of kin: _____

8. Name of informant: _____

9. Name of registrar: _____

10. Name of registrar: _____

11. Name of registrar: _____

12. Name of registrar: _____

13. Name of registrar: _____

14. Name of registrar: _____

15. Name of registrar: _____

16. Name of registrar: _____

17. Name of registrar: _____

18. Name of registrar: _____

19. Name of registrar: _____

20. Name of registrar: _____

21. Name of registrar: _____

22. Name of registrar: _____

9550

CERTIFICATE OF DEATH

09472
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P. GEO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE-RURAL			c. LENGTH OF STAY IN 1b 1 1/2 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #4 MARBURY ROAD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM EDGAR KENNEDY			4. DATE OF DEATH Month Day Year AUG 27 1960		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 2-1882		9. AGE (In years lost birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) KANSAS	
13. FATHER'S NAME CHARLES A. KENNEDY			14. MOTHER'S MAIDEN NAME MARGARET ROSS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT DAUGHTER Address MRS. MIRIAM MUDD #4 MARBURY RD. BRANDYWINE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE FAILURE DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO 3 YRS. (c) DISEASE INTERVAL BETWEEN ONSET AND DEATH 15 MIN.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour 9 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from FEB. 1960 to Present , that I last saw the deceased alive on MARCH 30, 1960 , and that death occurred at 7:00 M., from the causes and on the date stated above. NOTE: This certificate signed with permission of Dr. W. H. Williams DATE SIGNED 8/27/60 ACTUAL SIGNATURE Arthur Shaver Jr. M.D. BRANCH AVE. CLINTON, MD. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. MD. BRANCH AVE. CLINTON, MD. 8/27/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-31-60		22c. NAME OF CEMETERY OR CREMATORY St Vincent DeBul Cem	
22d. LOCATION (City, town, or county) Rogers, Arkansas		22e. (State)		22f. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The HUNTT Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR Arthur S. Kline	
DATE AUG 30 1960		24b. REGISTRAR'S SIGNATURE		24c. (State)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

9551

Item 14 Film G269 8-26-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 09473

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY P. GEO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-CLINTON				c. LENGTH OF STAY IN 1b 1951			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 1 BOX 360				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH SANDERS KING				4. DATE OF DEATH Month Day Year AUG. 21 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 3-1889	9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) WALDORF-MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES THOMAS KING				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-38-2207		INFORMANT JOSEPH ANDERSON KING-SON		Address RT 1 BOX 353 CLINTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 ACUTE PULMONARY EDEMA DUE TO CHRONIC SEVERE CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO 5 YR.						INTERVAL BETWEEN ONSET AND DEATH 1 HR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION (a) NONE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 1958 to PRESENT that I last saw the deceased alive on AUG. 20, 1960 , and that death occurred at 8 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur Shaver Jr. M.D.				ADDRESS (Street, city or town, state) BRANCH AVE. Clinton Md. 21740			
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.				DATE SIGNED 8/24/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-24-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Sutland MD	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. ADDRESS 1665 North Howard St WASH DC				24a. REC'D BY REGISTRAR DATE AUG 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Shaver	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1913

CERTIFICATE OF DEATH

8531

(14)

(1)

Attest my hand and seal of office this 14th day of August 1913.

W. W. [Signature]

NOTARY PUBLIC

NOTARY PUBLIC

Aug 20 1913

Attest my hand and seal of office this 20th day of August 1913.

W. W. [Signature]

NOTARY PUBLIC

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9476

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09474

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY in 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PRINCE GEORGE'S GEN HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. d. STREET ADDRESS 920 F ST. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWIN P. LANGE				4. DATE OF DEATH AUG 10 1960			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH AUG 15 1901	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OSCAR G LANGE				14. MOTHER'S MAIDEN NAME HELEN E HOFFMANN ENDERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. YES		17. INFORMANT MRS BARBARA BITTNER Address 6424 FAIRBANKS ST CARROLLTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 8/10/60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
burial		8/13/60		Ft. Lincoln Cemetery		Prince George, Md.	
23. FUNERAL DIRECTOR The S.H. Hines Co. Washington 9, D.C.				24a. REC'D BY REGISTRAR AUG 12 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

END 2
END 1

(M)

(1)

RECEIVED
FEB 10 1941
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS(RURAL)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARLBORO			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS RFD BOX 2552			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) SARAH First M/B Middle LUVENIA Last LAPRADE				4. DATE OF DEATH Month Aug Day 10 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE NEGROID		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 10, 1960	
9. AGE (In years last birthday) — yrs.		IF UNDER 1 YEAR Months — Days —		IF UNDER 24 HRS. Hours 2 Min. 30			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJAMIN F LAPRADE				14. MOTHER'S MAIDEN NAME Maudie S. Dockett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NA		INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE EDEMA 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PREMATURITY						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 HOURS	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 0550 19 60 , to 10 Aug 19 60 , that I last saw the deceased alive on 0630 10 Aug 19 60 , and that death occurred at 0820 M , from the causes and on the date stated above.							
ACTUAL SIGNATURE William F Peterson		M.D. USAF HOSPITAL ANDREWS		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS		DATE SIGNED 10 August 60	
PHYSICIAN'S NAME (Type) WILLIAM F PETERSON LCOL USAF MC		ANDREWS AIR FORCE BASE WASHINGTON 25 DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 11/60		22b. DATE THEREOF 11/60		22c. NAME OF CEMETERY OR CREMATORY C. Morgan - Washington D.C.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

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DECEASED

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DEPARTMENT OF HEALTH

STATE OF NEW YORK

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9442

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09477

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Pr George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Ramer</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Ramer</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		46	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3330 Buchanan St.</u>		d. STREET ADDRESS <u>33 30 Buchanan</u>	
3. NAME OF DECEASED (Type or print) <u>(Lydia) First</u> <u>ANN</u> Middle <u>LESCALLET</u> Last <u>Aug 31</u> 19 <u>60</u>		4. DATE OF DEATH	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1871 May 18 - 1900</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Simon Peter Eves</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Hilderbrand</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Francis Spunk</u>		Address <u>3330 Buchanan Mt. Ramer</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic Heart disease</u> (c) <u>few hours</u> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-31-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-3-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Libertytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Daily</u> ADDRESS <u>Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE SEP 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton L. House</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9477 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09476**

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Cheverly Manor, Md.	
f. STREET ADDRESS 6316 Kilmer Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jesse Middle Lescallett Last Jr		4. DATE OF DEATH Month Aug. Day 27 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 12, 1936
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months 24 Days 27	IF UNDER 24 HRS. Hours 24 Min. 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Technician		10b. KIND OF BUSINESS OR INDUSTRY John Hopkins Research	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jesse Lescallett		14. MOTHER'S MAIDEN NAME Delsie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Delsie Lescallett		Address Cheverly Manor, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 60%;"> Multiple internal injuries Pronounced (head, chest, & pelvis) </div> <div style="width: 10%;"> INTERVAL BETWEEN DEATH AND EXAMINATION 30 min later </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision, Thrown through Windshield of car	
20c. TIME OF INJURY Month, Day, Year 1102 Hour 8 g.m. 27 p.m. 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bowie, Md. Street	
20f. (City or town) Bowie, PG, MD.		(County) PG, MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE William D. Rosson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Rosson		DATE SIGNED 8/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-30-60	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Gasch, 4739 Balto. Ave., Hyattsville		24a. REC'D BY REGISTRAR AUG 31 '60	
ADDRESS Wm. F. Gasch, 4739 Balto. Ave., Hyattsville		24b. REGISTRAR'S SIGNATURE Arthur L. Hous	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09478

Reg. Dist. No.

9478

Items 8, 9 Film G272 10-3-60 et

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Riverdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>		d. STREET ADDRESS <u>15407 TAYLOR</u>	
3. NAME OF DECEASED (Type or print) <u>STELLA MADELINE LICWALD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-5-06</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS F SCRIBNER</u>		14. MOTHER'S MAIDEN NAME <u>SARA ANN HARDY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5407-TAYLOR</u>	
17. INFORMANT <u>LOUIS LICWALD</u>		Address <u>5407-TAYLOR</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease</u> DUE TO <u>(Coronary Sclerosis)</u> (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		DATE SIGNED <u>8-31-60</u>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-3-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee J. Francis Home - Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9479

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewery</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>				d. STREET ADDRESS <u>5420-56 ave</u>			
3. NAME OF DECEASED (Type or print) <u>Lewis Earl Middle Lowery</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17 1882</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. worker</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Ellerslie</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN W LOWERY</u>				14. MOTHER'S MAIDEN NAME <u>ANNA COX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>005-10-7854</u>		17. INFORMANT <u>Mrs Norma Long</u> Address <u>5420 Riverdale Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Surgical Shock</u> DUE TO <u>Wounds multiplex & Severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Lacerat at Kidney, Fracture of femur</u> DUE TO <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>inst</u> <u>inst</u> <u>inst</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Subject hit by a car</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8-23</u> 19 <u>60</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Riverdale Pr Geo Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton O. Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Hafer</u>				24a. REC'D BY REGISTRAR <u>AUG 29 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9517 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09480											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KMY Riverdale						c. LENGTH OF STAY IN 1b Dead on arrival Laurel					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital						e. STREET ADDRESS 211 Main Street					
3. NAME OF DECEASED (Type or print) Robert Irving MacCord						4. DATE OF DEATH August 13 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1914 46 yrs.		9. AGE (In years last birthday) Months Days		IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook						10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) District of Columbia U. S. A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Irving Mac Cord						14. MOTHER'S MAIDEN NAME Helen Capron					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-10-2117		17. INFORMANT Robert I. MacCord		2303 53rd Ave S.E. Bradbury Heights, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 902.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of the base of the skull and sternum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell from a porch roof							
20c. TIME OF INJURY Month, Day, Year 6:00 xx p.m. 8/13/60				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard of hotel Laurel		20f. (City or town) P. G.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/14/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-18-1960		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln, Cemetery		22d. LOCATION (City, town, or country) (State) Bladensburg, Md			
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.						ADDRESS		24a. REC'D BY REGISTRAR AUG 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



1

MAINTAIN A SYSTEMATIC RECORD OF DEATHS
DEATH CERTIFICATE OF DEATH
1935

Princess George's
Maryland
Dead on arrival Laurel
311 Main Street
Robert Irving MacGord
August 17 1935
White
Restaurant
District of Columbia U. S. A.
Robert Irving MacGord
Helen Gordon
3707 Ford Ave S.E.
Robert I. MacGord
Hemorrhage and shock
Fracture of the base of the skull on 4 afternoon
Fall from a porch roof
Yard of hotel Laurel P. D. Md.
James I. Boyd
8/17/35

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9480
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09481

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 14 Hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Samuel M. Malay				4. DATE OF DEATH Aug. 22 19 60			
5. SEX Male		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-21-06	
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		11. BIRTH PLACE (State or foreign country) Gloucester Co. Va.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Alexander J. Malay				14. MOTHER'S MAIDEN NAME V. Mary Deal Gwynn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 144-38-4433			
17. INFORMANT Samuel M. Malay Jr.				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portne heart failure DUE TO hypertens. H.S. Ht dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 15 hours (c) 1 year						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 22 1960 , to Aug. 22, 1960 , that (I) (we) last saw the deceased alive on Aug. 22 1960 , and that death occurred at 8:25 pm from the causes and on the date stated above.							
22a. SIGNATURE Leon L. Levitsky				22b. DATE SIGNED 8/23/60		22c. PHYSICIAN'S NAME (Type) Leon L. Levitsky	
22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/26/60		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Coeman Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc.				25a. REC'D BY REGISTRAR DATE AUG 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

(M)

0480

CENTRAL BANK OF INDIA

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09482

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Pr Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>VA</i> b. COUNTY <i>Dickenson</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chewers</i>	c. LENGTH OF STAY IN 1b <i>2 hrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CLINCH CO VA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Geo General</i>		d. STREET ADDRESS <i>83X-3</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>JAMES ARVIN MARSHALL</i>		4. DATE OF DEATH Month <i>August</i> Day <i>23</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 7-1934</i>
9. AGE (In years last birthday) <i>26</i> yrs.		10. IF UNDER 1 YEAR Months <i>26</i> Days <i>26</i> Hours <i>26</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Coal Miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tennessee</i>	
11. BIRTHPLACE (State or foreign country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Marshall</i>		14. MOTHER'S MAIDEN NAME <i>Susie Bartley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>76</i>	
17. INFORMANT <i>Bobby Marshall</i>		Address <i>Chinchoo ra</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SURGICAL SHOCK</i> <i>816X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>FRACTURE SKULL</i> 1 hr DUE TO (c) <i>1 hr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Automobile accident - mvr</i>	
20c. TIME OF INJURY Month, Day, Year <i>12 22 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Dickson</i>	20f. (City or town) (County) (State) <i>Bowie Pr Geo md</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Dayton Watkins</i> M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) <i>DAYTON WATKINS</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>8/24/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Colley Funeral Home</i>	22d. LOCATION (City, town, or county) (State) <i>Clintonwood Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gaski Sons Hyattsville, Md</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 26 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>William S. K...</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9553

CERTIFICATE OF DEATH

09483

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS (RURAL) c. LENGTH OF STAY IN 1b 45 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS (RURAL) 12 d. STREET ADDRESS 6968 ALLENTOWN ROAD 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SANDRA Middle LYN Last MARTIN		4. DATE OF DEATH Month AUGUST Day 22 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 OCTOBER 1959
9. AGE (In years last birthday) 10		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEWIS G MARTIN		14. MOTHER'S MAIDEN NAME BETTY LOU FARLET	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NA		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT LEWIS G MARTIN (RATHER)		Address SAME AS 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 45 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 August , 19 60 , to 21 August , 19 60 , that I last saw the deceased alive on 21 AUGUST , 19 60 , and that death occurred 11:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Jerome Tilles		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS DATE SIGNED 21 AUGUST 1960	
PHYSICIAN'S NAME (Type) JEROME TILLES, CAPT USAF MC		USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-25-60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) FREDERICKTOWN OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME, 816 11 ST. N.E., DC 22		ADDRESS 816 11 ST. N.E., DC 22	
24a. REC'D BY REGISTRAR AUG 24 '60		24b. REGISTRAR'S SIGNATURE William S. Hearn	

2050253XV3

CERTIFICATE OF DEATH

1955

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

TIME

DATE

PLACE OF DEATH

NAME OF PHYSICIAN

SIGNATURE

DATE

TIME

PLACE

NAME OF PHYSICIAN

SIGNATURE

DATE OF BIRTH

AGE

SEX

PLACE

CAUSE OF DEATH

DATE OF BIRTH

AGE

NAME OF PHYSICIAN

SIGNATURE

DATE OF BIRTH

AGE

PLACE OF BIRTH

CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9554

CERTIFICATE OF DEATH

Reg. Dist. No. 09484

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS (RURAL) c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB d. STREET ADDRESS MOQ 1-66-2 COLUMBUS CIRCLE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM S MILLER JR			4. DATE OF DEATH Month Day Year AUGUST 5 19 60				
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 28 DECEMBER 1959		9. AGE (In years lost birthday) yrs. 7		IF UNDER 1 YEAR Months 7 Days 8 Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? USAF							
13. FATHER'S NAME WILLIAM S MILLER SQ				14. MOTHER'S MAIDEN NAME ANNELLE NORTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT HOSPITAL RECORDS		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3 AUGUST , 19 60 , to 5 AUGUST , 19 60 , that I last saw the deceased alive on 5 AUGUST , 19 60 , and that death occurred at 1110AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE John A Moore M.D. USAF HOSPITAL ANDREWS 5 AUGUST 1960 PHYSICIAN'S NAME (Type) JOHN A MOORE CAPT USAF MC USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL AUG 8-1960		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY U.S.N.A.			
22d. LOCATION (City, town, or county) (State) ANAPOLIS, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 2050293XVS		24a. REC'D BY REGISTRAR DATE Aug 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

1918

CERTIFICATE OF DEATH

1918

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY

CAUSE OF DEATH

DIAGNOSIS

DATE OF BIRTH

SEX

AGE

PLACE OF BIRTH

NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

1918

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY

CAUSE OF DEATH

DIAGNOSIS

DATE OF BIRTH

SEX

AGE

PLACE OF BIRTH

NAME OF PHYSICIAN

may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9518

09485

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>27 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Meland Memorial Hosp</u>				d. STREET ADDRESS <u>4227 Madison</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Moxley</u> Last <u>Moxley</u>				4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-'85</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Columbus Rowe</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-12-2686</u>		17. INFORMANT <u>Hospital Record</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>3322x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arterio sclerosis</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks undetermined</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 2</u> 19 <u>60</u> to <u>Aug 29</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Aug 29</u> 19 <u>60</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>LW Malin</u>				22b. DATE SIGNED <u>8-29-60</u>		22c. PHYSICIAN'S NAME (Type) <u>LW Malin MD</u>	
22d. ADDRESS <u>Riverdale, Md</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/1/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Epheais</u>		23d. LOCATION (City, town, or county) (State) <u>Foneswood, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 1 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

10/10/1910

4-15-77

CERTIFICATE OF DEATH

Reg. Dist. No.

09486

9482

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGE'S GEN HOSPITAL</u>				d. STREET ADDRESS <u>3712 BLADENSBURG RD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HANNAH</u> Middle <u>C.</u> Last <u>MURPHY</u>				4. DATE OF DEATH Month <u>AUG</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 19 1869</u>	
9. AGE (In years last birthday) yrs. <u>91</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN SCHNEIDER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>JOHN A. SMITH</u> Address: <u>6105 QUEENS CHAPEL RD HYATTSVILLE, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUB ARACHNOID CVA</u> DUE TO <u>HYPERTENSIVE CRISIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SENILE SCLEROSIS GENERALIZED</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u> <u>5 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 22, 1960</u> , to <u>Aug 24, 1960</u> , that I last saw the deceased alive on <u>Aug 24, 1960</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin S. Miller</u> M.D.				ADDRESS (Street, city or town, state) <u>3824-34th N. Rainer</u> DATE SIGNED <u>8/24/60</u>			
PHYSICIAN'S NAME (Type) <u>BENJAMIN S. MILLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>AUG 27, 1960</u>		<u>GLENGOOD CEMETERY</u>		<u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u> ADDRESS <u>RIVERDALE, MD</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9488

9488

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>10/15/1918</i>	
5. PLACE OF DEATH <i>Home</i>		6. CITY <i>Baltimore</i>		7. COUNTY <i>Harford</i>		8. STATE <i>Md.</i>	
9. OCCUPATION <i>Engineer</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. DISEASE OR INJURY <i>Myocarditis</i>		12. PERIOD OF ILLNESS <i>2 weeks</i>	
13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. NAME OF FUNERAL HOME <i>None</i>		15. NAME OF BURIAL PLACE <i>None</i>		16. NAME OF CEMETERY <i>None</i>	
17. NAME OF NEXT OF KIN <i>John J. Smith</i>		18. NAME OF WITNESS <i>John J. Smith</i>		19. NAME OF REGISTRAR <i>John J. Smith</i>		20. NAME OF CLERK <i>John J. Smith</i>	
21. NAME OF DECEASED'S MOTHER <i>John J. Smith</i>		22. NAME OF DECEASED'S FATHER <i>John J. Smith</i>		23. NAME OF DECEASED'S SISTER <i>John J. Smith</i>		24. NAME OF DECEASED'S BROTHER <i>John J. Smith</i>	
25. NAME OF DECEASED'S WIFE <i>John J. Smith</i>		26. NAME OF DECEASED'S CHILDREN <i>John J. Smith</i>		27. NAME OF DECEASED'S GRANDCHILDREN <i>John J. Smith</i>		28. NAME OF DECEASED'S GREAT-GRANDCHILDREN <i>John J. Smith</i>	
29. NAME OF DECEASED'S NEPHEWS <i>John J. Smith</i>		30. NAME OF DECEASED'S UNCLE <i>John J. Smith</i>		31. NAME OF DECEASED'S AUNT <i>John J. Smith</i>		32. NAME OF DECEASED'S COUSINS <i>John J. Smith</i>	
33. NAME OF DECEASED'S IN-LAWS <i>John J. Smith</i>		34. NAME OF DECEASED'S OUT-LAWS <i>John J. Smith</i>		35. NAME OF DECEASED'S STEPPARENTS <i>John J. Smith</i>		36. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	
37. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		38. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		39. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		40. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	
41. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		42. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		43. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		44. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	
45. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		46. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		47. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		48. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	
49. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		50. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		51. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		52. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	
53. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		54. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		55. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		56. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	
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73. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		74. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		75. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		76. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	
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81. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		82. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		83. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		84. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	
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93. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		94. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		95. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		96. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	
97. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		98. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		99. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>		100. NAME OF DECEASED'S STEPPHILTONS <i>John J. Smith</i>	

10/15/1918

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. PLACE OF DEATH
6. CITY
7. COUNTY
8. STATE
9. OCCUPATION
10. CAUSE OF DEATH
11. DISEASE OR INJURY
12. PERIOD OF ILLNESS
13. NAME OF PHYSICIAN
14. NAME OF FUNERAL HOME
15. NAME OF BURIAL PLACE
16. NAME OF CEMETERY
17. NAME OF NEXT OF KIN
18. NAME OF WITNESS
19. NAME OF REGISTRAR
20. NAME OF CLERK
21. NAME OF DECEASED'S MOTHER
22. NAME OF DECEASED'S FATHER
23. NAME OF DECEASED'S SISTER
24. NAME OF DECEASED'S BROTHER
25. NAME OF DECEASED'S WIFE
26. NAME OF DECEASED'S CHILDREN
27. NAME OF DECEASED'S GRANDCHILDREN
28. NAME OF DECEASED'S GREAT-GRANDCHILDREN
29. NAME OF DECEASED'S NEPHEWS
30. NAME OF DECEASED'S UNCLE
31. NAME OF DECEASED'S AUNT
32. NAME OF DECEASED'S COUSINS
33. NAME OF DECEASED'S IN-LAWS
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90. NAME OF DECEASED'S STEPPHILTONS
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99. NAME OF DECEASED'S STEPPHILTONS
100. NAME OF DECEASED'S STEPPHILTONS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09487

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>			
c. LENGTH OF STAY IN 1b <u>week</u>				d. STREET ADDRESS <u>5210 Middleton Ln</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7150 Brindley Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Magdalen</u> Last <u>Murphy</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 15, 1881</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Zephania Wade</u>				14. MOTHER'S MAIDEN NAME <u>Esther Frances Mudd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Dr. C. L. Walter</u>				Address <u>San Francisco #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES H. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-12-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Sutland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Boyd</u> ADDRESS <u>1661 - Good Hope Rd SE Wash. 20 20</u>				24a. REC'D BY REGISTRAR <u>Aug 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9436

09488

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY in 1b 14 approx. mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Regina Myers First Middle Last				4. DATE OF DEATH August 14 1960 Month Day Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-10-'78	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) St. Boniface, Penn.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Anthony Anstead				14. MOTHER'S MAIDEN NAME Catherine Noel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Sr. M. Francis Patricia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) CARCINOMA OVARY DUE TO (c) 1938				INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12 Aug 1960 to 14 Aug 1960 , that (I) (we) lost saw the deceased alive on 14 Aug 1960 , and that death occurred at 11:01 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert J. Murphy				22b. DATE SIGNED 14 Aug 60			
22c. PHYSICIAN'S NAME (Type) W. Howard Yeager, Jr. M.D.				22d. ADDRESS 1800 CONN AVE N.W. WASH D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 17th, 1960		23c. NAME OF CEMETERY OR CREMATORY Northside Catholic		23d. LOCATION (City, town, or county) (State) Pittsburgh, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert J. Murphy				ADDRESS 3524 Columbia Pike Arlington, Va.		25a. REC'D BY REGISTRAR DATE AUG 17 '60	
				25b. REGISTRAR'S SIGNATURE C. S. Hume			

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CERTIFICATE OF DEATH

9230



1. Name of deceased: [Illegible]
2. Sex: [Illegible]
3. Age: [Illegible]
4. Date of birth: [Illegible]
5. Date of death: [Illegible]
6. Place of death: [Illegible]
7. Cause of death: [Illegible]
8. Signature of physician: [Illegible]
9. Signature of registrar: [Illegible]
10. Date of registration: [Illegible]



PAID IN FULL

9483

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09489

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton & E. Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN. Hospital</u>		d. STREET ADDRESS <u>15515 Nicholson St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>J.</u> Last <u>Needham</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan 13, 1931</u>
9. AGE (In years lost birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asbestos Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D. C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
3. FATHER'S NAME <u>Robert J. Needham, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Rosa R. Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Rosa R. M. Needham</u> Address <u>5515 Nicholson St Riverdale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IN FRACTION OF R INTERNAL CAPSULE</u> DUE TO <u>PRIMARY THROMBOSIS of R INTERNAL CAROTID</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/1/60</u> 19 <u> </u> to <u>8/18/</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8/17/</u> 19 <u>60</u> and that death occurred at <u> </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Albert Roth</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT ROTH</u>		22d. ADDRESS <u>3510 Madison St. Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-22-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Wheaton, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>Riverdale, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 24 '60</u>	25b. REGISTRAR'S SIGNATURE <u>G. S. R. R.</u>

10110

CERTIFICATE OF DEATH

1883

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10110

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9484 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 62			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hosp.				d. STREET ADDRESS 4515 Buchanan Street 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elmer First Albaugh Middle Norris Last				4. DATE OF DEATH Aug Month 28 Day 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 Mar 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Guard		10b. KIND OF BUSINESS OR INDUSTRY U.S. G vt.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry J. Norris				14. MOTHER'S MAIDEN NAME Mary M. Albaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Ottilie L. Norris (Wife) Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular disease (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William D. Rosson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/28/60			
EXAMINER'S NAME (Type) William D. Rosson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/60		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE AUG 31 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

Abstract

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3.

1. *Chlorophyll a* (Chl *a*)

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9507

CERTIFICATE OF DEATH

Reg. Dist. No. 09491

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colmar Manor</i>		c. LENGTH OF STAY IN 1b <i>15 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3509 43rd. Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thomas Peter</i> First Middle Last <i>O'Neill</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>30</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>20 June 1870</i>
9. AGE (In years lost birthday) <i>90 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Harness maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Leather</i>	
11. BIRTHPLACE (State or foreign country) <i>Dublin Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John O'Neill</i>		14. MOTHER'S MAIDEN NAME <i>Budget Reardon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>011-18-3190</i>	
17. INFORMANT <i>James H. O'Neill</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senile myocarditis and</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>insufficiency of generalized</i> DUE TO (c) <i>arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Totally blind 10 years</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1954</i> to <i>30 Aug 1960</i> that I last saw the deceased alive on <i>27 Aug 1960</i> and that death occurred at <i>6 am</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>2200 R. 9. Ave N.E. 18</i> DATE SIGNED <i>18</i>			
ACTUAL SIGNATURE <i>Thomas F. Mattingly M.D.</i>		PHYSICIAN'S NAME (Type) <i>Thomas F. Mattingly M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Transportation</i>		22b. DATE THEREOF <i>8/30/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Griffin & Aldridge Funeral Home</i>		22d. LOCATION (City, town, or county) (State) <i>Rome N. Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>SEP 1 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Carlton L. K...</i>	

10000

CERTIFICATE OF DEATH

10507

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Form with multiple sections for recording death statistics, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

10000



1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

9485 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Farmington Heights</u>	
c. LENGTH OF STAY IN 1b <u>1 1/4 hours</u>		d. STREET ADDRESS <u>5705 1st Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rosella Louise Parker</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1926</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Edward Spenser</u>		14. MOTHER'S MAIDEN NAME <u>Mary Banks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>John W. Parker, same as #2</u>	
17. INFORMANT <u>John W. Parker, same as #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cranial hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertensive heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR <u>Robert M. Smith</u>		24a. REC'D BY REGISTRAR <u>AUG 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>		DATE	

09494

8-9-60

10000

FOR STATE
FATHI DUE



John C. Smith
Hypertension

James E. Smith
1940-1941

Washington, D.C.
1940-1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9486

09492

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b 1 1/2 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencer City	
4. NAME OF DECEASED (Type or print) First Zella Middle Oscar Last Parks		4. DATE OF DEATH Month August Day 15 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-91
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Hope Nat. Gas. Co	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Parks		14. MOTHER'S MAIDEN NAME Sarah Jane Cline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 236 10 4850	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) ACUTE MYOCARDIAL INFARCTION (c) ARTERIO SCLEROTIC HEART DISEASE. INTERVAL BETWEEN ONSET AND DEATH 49D			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-28-1960 to 8-15-1960 that (I) (we) last saw the deceased alive on 8-15-1960 , and that death occurred 10:10 p.m. the causes and on the date stated above.			
22a. SIGNATURE H. David Kerr, M.D.		22b. DATE SIGNED 8-16-60	
22c. PHYSICIAN'S NAME (Type) Dr. Kerr., M.D.		22d. ADDRESS 9812 49th Ave. College Park, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/19/1960	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial		23d. LOCATION (City, town, or county) (State) Clarksburg, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25a. REC'D BY REGISTRAR AUG 18 '60	
ADDRESS 300 4th St. N.E.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1999

5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042

VS. A15ME
5M 7/59

09493

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George Gen. Hospital		d. STREET ADDRESS 7302 Hughes Ave 02X-2	
3. NAME OF DECEASED (Type or print) Louis Fredrick PAUL Jr.		4. DATE OF DEATH Aug 19 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 July 1949
9a. AGE (In years last birthday) 11 yrs.		9b. IF UNDER 1 YEAR Months 11 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Fredrick Paul Sr.		14. MOTHER'S MAIDEN NAME Nellie E. Gasser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Nellie Gasser Paul		Address same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 822X DUE TO 7 fractured skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Car overturned on roadway	
20c. TIME OF INJURY Month, Day, Year 8:00 a.m. 8-18-60		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 3		20f. (City or town) (County) (State) Mitchellville MS. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) Colgate, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 22, 1960	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or country) (State) Colgate, Md.	
23. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR DATE AUG 24 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

100-100000



George Prince

George Prince

George Prince, Hospital

George Prince

George Prince

Louis

Frederick Paul Jr.

White

17 July 1949

School

Maryland

U.S.A.

Louis Frederick Paul Sr.

Mollie F. Ganser

None

Mrs. Mollie Ganser Paul

Auto car

James I. Boyd

8/10/50

1
4
M
077
OK by CONDNER 8/29/60
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in approved, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RECORDS AND RECORDS — BALTIMORE 1, MARYLAND

9488

CERTIFICATE OF DEATH

09495

Items 8, 9 Film 6271 9-15-60 et

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESVERTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENERAL Hosp.</u>		d. STREET ADDRESS <u>4100 Quintana Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last		4. DATE OF DEATH <u>August 29</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 29, 1903</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Reif</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Buck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Harry Webster Penn</u>	
17. INFORMANT <u>Harry Webster Penn</u> Address <u>Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>Aug 29</u> , 19 <u>60</u> that (I) (we) lost the deceased alive on <u>Aug 27</u> , 19 <u>60</u> and that death occurred at <u>11:25</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman Donat Breaux</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/29/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BREAUX</u>		22d. ADDRESS <u>3503 Perry W. Mt Rainier Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/1/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 6 '60</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

00407

CERTIFICATE OF DEATH

0488



2100

1905

10-0-10000

10000

100

10000 10000 10000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9489

09496

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENERAL Hospital</u>				d. STREET ADDRESS <u>5807 44th AVE. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>HERMAN</u> Last <u>PICKENS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-3-74</u>	
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superior Creamery</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>John W. Pickens</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Miss Marion Pickens</u> Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Heart Disease</u> DUE TO (c) <u>Decelerated heartbeat</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-5</u> 19 <u>50</u> to <u>8-28</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8-27</u> 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. Deitz M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>G. Deitz M.D.</u>				22d. ADDRESS <u>4313 Hallitank, Hyattsville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8-30-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co Riverdale, Md</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kious</u>	

1

2

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00100

CENTRAL OF DEATH

0310



[Faint, mostly illegible text, possibly a list or ledger entries, spanning the main body of the page.]

VS. A15ME
5M 7/59

09495

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		b. COUNTY	
Prince George's		Maryland		Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cheverly		Dead on arrival		Clinton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince George's General Hospital		Daingerfield Drive			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX	
First Middle Last		Month Day Year		Male Female	
Clara Illistrrious Plager		August 2, 1960		Female	
6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
White				June 27, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Secretary		Office		District of Columbia U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Milton W. Plager		Sallie Virginia Turner		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				1206 Ingraham N. W. Alice E. Griffith, Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure					
442X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
Cancer of the colon					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	
19					
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		Aug 4, 1960		Glenwood Cem.	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
W.W. Chambers Co. Riverdale, Md.		AUG 4 '60		C. S. Thomas	

RECEIVED
JUN 27 1954



Prince George's

Maryland

Prince George's

Overly

Dead on arrival

Prince George's General Hospital

Unidentified

Office

August 5, 1950

Female

June 27, 1954

Secretary

Office

District of Columbia U.S.A.

Milton W. Plager

Salie Virginia Turner

1306 Ingraham N.W.
Alice E. Griffith, Washington, D.C.

acute congestive heart failure

Cardiovascular renal disease

Cancer of the colon

X

X

X

X

August 5, 1950

James I. Boyd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9556

CERTIFICATE OF DEATH

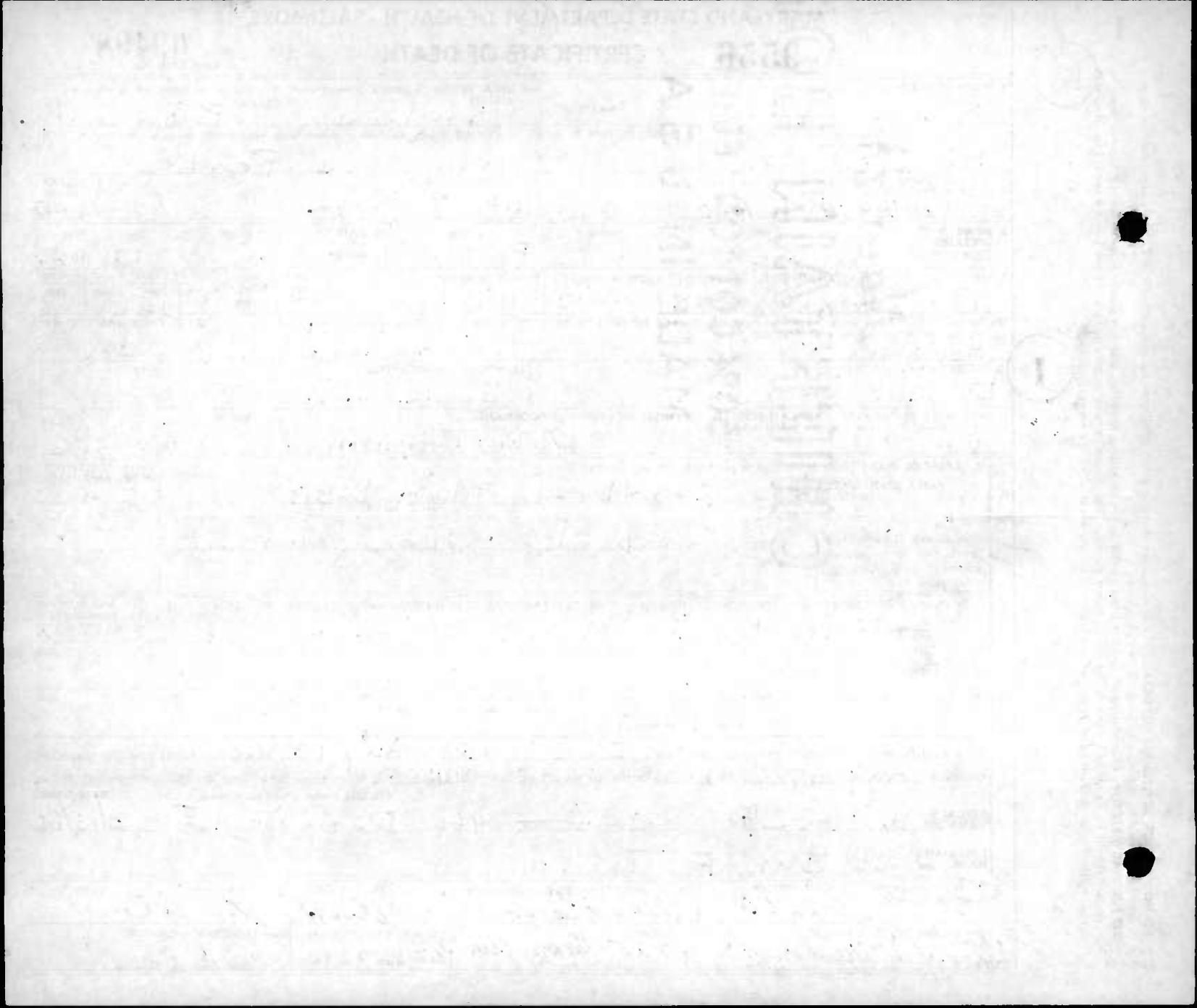
09498

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1114-70th Ave</u>				d. STREET ADDRESS <u>1114-70th Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie</u> <u>Plater</u>				4. DATE OF DEATH Month Day Year <u>Aug.</u> <u>18</u> <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/3/65</u>	9. AGE (In years last birthday) yrs. <u>94</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
3. FATHER'S NAME <u>Daniel Henson</u>				14. MOTHER'S MAIDEN NAME <u>Jane Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Highland Park Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>59</u> , to <u>Aug 18</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Aug 17</u> , 19 <u>60</u> , and that death occurred at <u>11:05 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilbur F. Jackson</u>				ADDRESS (Street, city or town, state) <u>4649 Deane Ave. N.E.</u> DATE SIGNED <u>8/18/60</u>			
PHYSICIAN'S NAME (Type) <u>Wilbur F. Jackson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>8-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Washington</u> ADDRESS <u>4925 Deane Ave</u>				24. REC'D BY REGISTRAR <u>NS</u> DATE <u>AUG 22 '60</u>		25. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09499

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Charley</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>			
c. LENGTH OF STAY IN 1b <u>8 hours</u>				d. STREET ADDRESS <u>Route 301</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas Elliott Proctor</u>				4. DATE OF DEATH <u>August 19 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 5, 1928</u>	
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver Hauling</u>				11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Hauling</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas S. Proctor</u>				14. MOTHER'S MAIDEN NAME <u>Alene Randall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>547-34-8565</u>			
17. INFORMANT <u>Elizabeth Hilda Proctor, Anne</u>				Address <u>Sty</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Compression</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intra cranial hemorrhage</u>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James H. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES H. BOYD</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>8-19-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 22 1960</u>		<u>Mt. Carmel</u>		<u>Upper Marlboro, Md.</u>	
23. FUNERAL DIRECTOR <u>Hunt & Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 24 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>William S. Thayer</u>			

MEDICAL CERTIFICATION

LOW HIGH
TIDE GAGE

(M)

(1)

1891

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1891

[Faint, mostly illegible text, likely a medical certificate or report, possibly containing names and dates.]

9557

CERTIFICATE OF DEATH

Reg. Dist. No. 09500

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL)-CAMP SPRINGS ONE HOUR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL)-WALDORF Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSPITAL ANDREWS</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marie Rabasa</u> First Middle Last				4. DATE OF DEATH <u>August-20</u> 19 <u>60</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>CAUCASIAN</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>21 AUG 60</u>	
9. AGE (In years lost birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1</u>		11. IF UNDER 24 HRS. <u>1</u>		12. IF UNDER 1 YEAR Months Days Hours Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JUAN RABASA</u>				14. MOTHER'S MAIDEN NAME <u>MINAKO HATTORI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>CHART</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extreme immaturity</u> DUE TO <u>Premature birth</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>One hour</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>21 Aug</u> , 19 <u>60</u> , to <u>21 Aug</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>21 Aug</u> , 19 <u>60</u> , and that death occurred at <u>249</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Moore</u> M.D.				ADDRESS (Street, city or town, state) <u>USAF HOSP ANDREWS 21 AUG 60</u>			
PHYSICIAN'S NAME (Type) <u>JOHN A. MOORE</u>				DATE <u>21 AUG 60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pelay</u>	
22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Thrane</u>	

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VS A15 (4)
15M 9/58

2050242XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920



1. Name of deceased (Print) *John J. Smith*

2. Sex *Male*

3. Age *45*

4. Date of death *Jan 15 1920*

5. Place of death *Home*

6. Cause of death *Heart*

7. Signature of physician *J. J. Smith*

8. Signature of registrar *J. J. Smith*

9. Signature of coroner *J. J. Smith*

10. Signature of undertaker *J. J. Smith*

11. Signature of funeral home *J. J. Smith*

12. Signature of cemetery *J. J. Smith*

13. Signature of church *J. J. Smith*

14. Signature of family *J. J. Smith*

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9519

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09501
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE		c. LENGTH OF STAY IN 1b 1 HOUR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ireland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLINTON Charles RECTOR		4. DATE OF DEATH AUG. 27 1960	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 7, 1904
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY US Govt	
11. BIRTHPLACE (State or foreign country) Independence, Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME John Rector		14. MOTHER'S MAIDEN NAME Flora E. McBride	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Flora E. Rector, Laurel, Md	
17. INFORMANT Flora E. Rector, Laurel, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL DAMAGE AND Hemorrhage 2hr DUE TO Pistol shot wound through Cranium 2hr Conditions, if any, which gave rise to immediate cause (b) Pistol shot wound through Cranium 2hr DUE TO Pistol shot wound through Cranium 2hr cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Self inflicted pistol shot wound	
20c. TIME OF INJURY 3:20 p.m. Month, Day, Year 8/27/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Laurel (County) Prince George's (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William D. Rossion MD		DATE SIGNED 8/27/60	
EXAMINER'S NAME (Type) WILLIAM D. ROSSON, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 30 1960	
22c. NAME OF CEMETERY OR CREMATORY St. Hill Cemetery		22d. LOCATION (City, town, or county) Laurel - Prince George's - Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Finnes		24a. REC'D BY REGISTRAR AUG 31 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Finnes			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02131



1. NAME OF DECEASED <i>John J. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>June 15, 1900</i>	
5. PLACE OF BIRTH <i>New York City</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF DEATH <i>May 10, 1945</i>	
9. PLACE OF DEATH <i>Home</i>		10. CAUSE OF DEATH <i>Myocardial Infarction</i>	
11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF EXAMINER <i>Dr. J. H. Jones</i>	
13. SIGNATURE OF NEXT OF KIN <i>John J. Smith, Jr.</i>		14. SIGNATURE OF WITNESSES <i>John J. Smith, Jr. & Mary J. Smith</i>	
15. SIGNATURE OF CLERK <i>John J. Smith</i>		16. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9559 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08502

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland p. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Myrtie Brown Regan		4. DATE OF DEATH Month Day Year Aug 1 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1873
9. AGE (In years last birthday) 87 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Gun Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel E Brown		14. MOTHER'S MAIDEN NAME Judith Howell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Carl Fenwick, same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James J. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES L. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-1-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home		ADDRESS Mt. Rainier Md.	
24a. REC'D BY REGISTRAR DATE AUG 5 '60		24b. REGISTRAR'S SIGNATURE William D. Evans	

may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9492

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09503

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Cheverly			
c. LENGTH OF STAY IN 1b 2 Days				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Baby Boy		First Reilly		Middle		Last	
4. DATE OF DEATH Aug. 19		Month		Day		Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1960	9. AGE (In years lost birthday) — yrs.	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 2 Hours — Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Gail Patricia Reilly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO (b) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 17 19 60 , to Aug. 19 19 60 , that (I) (we) last saw the deceased alive on Aug 19 1960 , and that death occurred at 1330 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE F.F. Musser				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) F.F. Musser				22d. ADDRESS 4410 74th Ave. Bellmead, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8-24-60		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly, MARYLAND		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator				25a. REC'D BY REGISTRAR SEP 7 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

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0550

CERTIFICATE OF DEATH

3493

(M)

(5)

Place of death: _____

Occupation: _____

Place of birth: _____

Age: _____

Sex: _____

Color: _____

Height: _____

Weight: _____

Build: _____

Complexion: _____

Scars: _____

Other: _____

Signature of physician: _____

Signature of registrar: _____

Signature of informant: _____

Signature of witness: _____

Signature of coroner: _____

Signature of jury: _____

Signature of judge: _____

Signature of clerk: _____

Signature of sheriff: _____

Signature of constable: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9493 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09504**

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PR GEO GENERAL, Church				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Pr Geo c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Ranier md d. STREET ADDRESS 4410 - 31 ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES BUCHANAN RICKS First Middle Last				4. DATE OF DEATH Aug 23 1968 Month Day Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13 1913 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOOD CLERK				10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME CHARLES C RICKS				14. MOTHER'S MAIDEN NAME ADA SARAH JOHNSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-63-4571		17. INFORMANT CARA RICKS MT RANIER MD Address 4410 - 31 ST			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident 331X DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 not	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis liver						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dayton Watkins M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) DAYTON O WATKINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 8-22-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md		24a. REC'D BY REGISTRAR DATE AUG 26 '60	
24b. REGISTRAR'S SIGNATURE <i>Charles L. Harris</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral home. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09505

9447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood c. LENGTH OF STAY IN 1b 6 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3710 Webster Street				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood 42 d. STREET ADDRESS 3710 Webster St 11 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Rider				4. DATE OF DEATH Month Day Year Aug 6 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIAGE STATUS MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov 26, 1889	
9. AGE (In years) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Born Anne Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Bladen				14. MOTHER'S MAIDEN NAME Bridgett Broderick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Gertrude E. Riley, same as address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 8-6-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE AUG 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

W117

1. NAME OF DECEASED [Faint handwritten name]		2. SEX [Faint handwritten sex]		3. AGE [Faint handwritten age]	
4. DATE OF DEATH [Faint handwritten date]		5. TIME OF DEATH [Faint handwritten time]		6. PLACE OF DEATH [Faint handwritten place]	
7. OCCUPATION [Faint handwritten occupation]		8. CAUSE OF DEATH [Faint handwritten cause]		9. MANNER OF DEATH [Faint handwritten manner]	
10. SIGNATURE OF MEDICAL EXAMINER [Faint handwritten signature]		11. SIGNATURE OF WITNESS [Faint handwritten signature]		12. SIGNATURE OF JURY [Faint handwritten signature]	
13. SIGNATURE OF DECEASED [Faint handwritten signature]		14. SIGNATURE OF NEXT OF KIN [Faint handwritten signature]		15. SIGNATURE OF CLERK [Faint handwritten signature]	
16. SIGNATURE OF CHURCH CLERK [Faint handwritten signature]		17. SIGNATURE OF BURIAL SOCIETY [Faint handwritten signature]		18. SIGNATURE OF FUNERAL HOME [Faint handwritten signature]	
19. SIGNATURE OF CEMETERY [Faint handwritten signature]		20. SIGNATURE OF STATE DEPARTMENT [Faint handwritten signature]		21. SIGNATURE OF HEALTH DEPARTMENT [Faint handwritten signature]	
22. SIGNATURE OF VITAL RECORDS [Faint handwritten signature]		23. SIGNATURE OF BIRTH RECORDS [Faint handwritten signature]		24. SIGNATURE OF DEATH RECORDS [Faint handwritten signature]	
25. SIGNATURE OF MARRIAGE RECORDS [Faint handwritten signature]		26. SIGNATURE OF DIVORCE RECORDS [Faint handwritten signature]		27. SIGNATURE OF ADULTERY RECORDS [Faint handwritten signature]	
28. SIGNATURE OF FUGITIVE RECORDS [Faint handwritten signature]		29. SIGNATURE OF PROBATION RECORDS [Faint handwritten signature]		30. SIGNATURE OF JAIL RECORDS [Faint handwritten signature]	
31. SIGNATURE OF COURT RECORDS [Faint handwritten signature]		32. SIGNATURE OF JURY RECORDS [Faint handwritten signature]		33. SIGNATURE OF VERDICT RECORDS [Faint handwritten signature]	
34. SIGNATURE OF JUDGMENT RECORDS [Faint handwritten signature]		35. SIGNATURE OF APPEAL RECORDS [Faint handwritten signature]		36. SIGNATURE OF REVERSAL RECORDS [Faint handwritten signature]	
37. SIGNATURE OF CONFIRMATION RECORDS [Faint handwritten signature]		38. SIGNATURE OF EXECUTION RECORDS [Faint handwritten signature]		39. SIGNATURE OF REMOVAL RECORDS [Faint handwritten signature]	
40. SIGNATURE OF RETURN RECORDS [Faint handwritten signature]		41. SIGNATURE OF RECEIPT RECORDS [Faint handwritten signature]		42. SIGNATURE OF DISCHARGE RECORDS [Faint handwritten signature]	
43. SIGNATURE OF RELEASE RECORDS [Faint handwritten signature]		44. SIGNATURE OF REENTRY RECORDS [Faint handwritten signature]		45. SIGNATURE OF RESIDENCE RECORDS [Faint handwritten signature]	
46. SIGNATURE OF CITIZENSHIP RECORDS [Faint handwritten signature]		47. SIGNATURE OF NATURALIZATION RECORDS [Faint handwritten signature]		48. SIGNATURE OF DEPORTATION RECORDS [Faint handwritten signature]	
49. SIGNATURE OF EXCLUSION RECORDS [Faint handwritten signature]		50. SIGNATURE OF INSPECTION RECORDS [Faint handwritten signature]		51. SIGNATURE OF INVESTIGATION RECORDS [Faint handwritten signature]	
52. SIGNATURE OF INTERVIEW RECORDS [Faint handwritten signature]		53. SIGNATURE OF EXAMINATION RECORDS [Faint handwritten signature]		54. SIGNATURE OF REPORT RECORDS [Faint handwritten signature]	
55. SIGNATURE OF SUMMARY RECORDS [Faint handwritten signature]		56. SIGNATURE OF CONCLUSION RECORDS [Faint handwritten signature]		57. SIGNATURE OF RECOMMENDATION RECORDS [Faint handwritten signature]	
58. SIGNATURE OF ACTION RECORDS [Faint handwritten signature]		59. SIGNATURE OF DECISION RECORDS [Faint handwritten signature]		60. SIGNATURE OF FINAL RECORDS [Faint handwritten signature]	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9494
Item 9 Film 270 4-6-60 et
CERTIFICATE OF DEATH

09506

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLEY</u>	c. LENGTH OF STAY IN 1b <u>14 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> <u>28</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GEN Hospital</u>		d. STREET ADDRESS <u>4907 166th AVE.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>E.</u> Last <u>Ridgley</u>		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AT 5-18-77</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Nicholas Johnson</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Brady A. Ridgley same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> <u>Neural failure</u> DUE TO (b) <u>Adv. ailed nephrosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer carcinoma of the colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8-13-</u> <u>1960</u> , to <u>Aug. 27, 1960</u> that (I) (we) last saw the deceased alive on <u>August 27 1960</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>C. D. Connor, M.D.</u>		22b. DATE SIGNED <u>Aug 27-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. D. CONNOR</u>		22d. ADDRESS <u>4410 - 74th Ave Belmad</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 30-60</u>		23b. DATE THEREOF <u>Aug 30-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sevier Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Bros</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. DATE <u>AUG 30 '60</u>	

25d. ADDRESS
1661 9d Hope Rd SE Wash 20 DC

8492

11TH EAT OF DEATH

08200

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "death" and "eaten" are faintly visible.]

CERTIFICATE OF DEATH

Reg. Dist. No. 09507

1. PLACE OF DEATH a. COUNTY PRINCE Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 2 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescent & Rest Home		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville d. STREET ADDRESS 08X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Julia Robey		4. DATE OF DEATH Month Day Year 8 3 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/80
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTH PLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John E. Dixon		14. MOTHER'S MAIDEN NAME Mary Rose Montgomery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-347957	
17. INFORMANT Raymond Robey		Address 1052 BUCHANAN ST. N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48h year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 14, 1960 , to August 3, 1960 , that I last saw the deceased alive on August 3, 1960 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE T. H. BERGEMANN		DATE SIGNED 4314 Galt Road, Hyattsville, Md.	
PHYSICIAN'S NAME (Type) T. H. BERGEMANN		Mary C. C. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 6, 1960	22c. NAME OF CEMETERY OR CREMATORY St. Mary's	22d. LOCATION (City, town, or county) (State) Bryantown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE AUG 10 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

Hunt Funeral Home - Waldorf, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Franklin's Home, 1100 2nd St NW
Burial Aug 1902 at Mary's

Brady's, Md.

No 250-2422

John E Dixon
Mary Rose Montgomery
Own home Maryland

Mary

CERTIFICATE OF DEATH

6/10/02

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9495

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>VA</u> b. COUNTY <u>Richmond</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTWOOD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>		d. STREET ADDRESS <u>RT #1</u>	
3. NAME OF DECEASED (Type or print) <u>LINDEN C. ROSE, JR</u>		4. DATE OF DEATH <u>August 23 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 21 1938</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab Assistant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineering</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LINDEN CLARENCE ROSE Sr</u>		14. MOTHER'S MAIDEN NAME <u>Dessie Flemming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>226 486194</u>	
17. INFORMANT <u>Dayton O Rose</u>		Address <u>12 a Sunset Dr Alexandria VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wounds, multiphase & severe</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Locustation liver, Locustation</u> (c) <u>Venacava - surgical shock</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident & MV</u>	
20c. TIME OF INJURY Month, Day, Year <u>8-23 1960</u> Hour a. m. <u>12 03</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Bonnie Pr Geo md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8/24/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Colley Funeral Home</u>		22d. LOCATION (City, town, or county) <u>Clintwood Va</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gusche Sons Hyattsville, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 26 '60</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9438

CERTIFICATE OF DEATH

Reg. Dist. No.

09509

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b 4 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Hyattsville Md		d. STREET ADDRESS 6643 23rd avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6643 23rd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Lee Rose		4. DATE OF DEATH Month Aug Day 24 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 29, 1900
9. AGE (In years lost birthday) 60 yrs.		10. FUND 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building inspector		10b. KIND OF BUSINESS OR INDUSTRY Pro Geo County	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles Rose		14. MOTHER'S MAIDEN NAME Edith Dates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Julia K Rose Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with DUE TO metastases involving brain spinal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. — cord & liver DUE TO — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 4 , 19 60 , to Aug 24 , 19 60 , that I last saw the deceased alive on Aug 21 , 19 60 , and that death occurred at 6:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1021 University Blvd E Silver Springs Md DATE SIGNED Richard L. Whelton			
ACTUAL SIGNATURE Richard L. Whelton		PHYSICIAN'S NAME (Type) Richard L Whelton	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/27/60	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE AUG 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

05500

STATE OF NEW YORK

0438

(M)

George J. ...

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09510

9496

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN 1b <u>1 hr. 10 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>17538 CLEVELAND AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Howard</u> Last <u>Russell</u>				4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1914</u>	9. AGE (In years last birthday) yrs. <u>45</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Empl'dy Chaeffer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Airlines Trans. Company</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Russell</u>				14. MOTHER'S MAIDEN NAME <u>Salome Childs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-5149</u>		17. INFORMANT <u>Edith A. Russell-Same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Congestive Heart failure -</u> DUE TO (c) <u>Coronary Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 12 Aug 1960</u> to <u>Aug 17, 1960</u> , that (II) (we) last saw the deceased alive on <u>12 Aug 1960</u> , and that death occurred at <u>1:58</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Thorne M. Lutchins</u>				22b. ADDRESS <u>7315 Landoner Rd</u>		22c. DATE SIGNED <u>14 Aug 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thorne M. Lutchins M.D.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/18/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>	23d. LOCATION (City, town, or county) <u>Upper Marlboro, Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Upper Marlboro</u>				25a. REC'D BY REGISTRAR <u>AUG 23 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Andrew S. Kneib</u>	

1250

CERTIFICATE OF DEATH

1250

1

[Faint, illegible text, likely bleed-through from the reverse side of the page]

VS. A15ME
5M 7/S9

Arthur S. Kraus

FOR STATE
DEATH CERTIFICATE

(M)

(A)

9330

DEATH CERTIFICATE OF STATE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9497

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09512

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. STREET ADDRESS 1100 64th Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Savoy Last Savoy				4. DATE OF DEATH Month August Day 6 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-12-07	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab orer		10b. KIND OF BUSINESS OR INDUSTRY Metal Finisher		11. BIRTHPLACE (State or foreign country) Chester, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Savoy				14. MOTHER'S MAIDEN NAME Minnie Swann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579 12 6781		17. INFORMANT Address. Mary Savoy 1100 64 Ave., Cedar Hgts, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO Carcinomatous Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Carcinoma of Pancreas DUE TO (c) Carcinoma of Pancreas							INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 4:45 PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 28 19 60 , to Aug. 6 19 60 , that (I) (we) last saw the deceased alive on Aug. 6 19 60 , and that death occurred at 4:45 PM on the causes and on the date stated above.							
22a. SIGNATURE Dr. C. James Duke				22b. DATE SIGNED Aug. 6 19 60		22c. PHYSICIAN'S NAME (Type) Dr. C. James Duke, M.D.	
22d. ADDRESS 6607 Riverdale Road, Riverdale MdD.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-10-60		23b. DATE THEREOF 8-10-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE M. K. Rollins				25a. REC'D BY REGISTRAR Aug 9 '60		25b. REGISTRAR'S SIGNATURE Dr. C. James Duke	

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0483

CERTIFICATE OF DEATH

0483

M

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9558 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G273 10-14-60 et

09513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine				c. LENGTH OF STAY IN 1b 15 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt #2 Box 281				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Last First Middle Last Sedley Balfour Shaw				4. DATE OF DEATH Month Day Year Aug 9 11 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 31, 1901	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army Officer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Kansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jeff Shaw				14. MOTHER'S MAIDEN NAME Bertha Balfour			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes 1919-1948				16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Betty Shaw, same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Polycythemia vera Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8/16/60		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEM.	
22d. LOCATION (City, town, or county) FORT MYER, VIRGINIA				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Smith				23b. ADDRESS 1756 PA. AVE., N.W. D.C. 6		24a. REC'D BY REGISTRAR DATE AUG 12 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
M.D. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF BIRTH: _____

5. PLACE OF BIRTH: _____

6. OCCUPATION: _____

7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

8. DATE OF DEATH: _____

9. PLACE OF DEATH: _____

10. CAUSE OF DEATH: _____

11. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED

12. SIGNATURE OF MEDICAL EXAMINER: _____

13. SIGNATURE OF WITNESS: _____

14. SIGNATURE OF CORONER: _____

15. SIGNATURE OF JURY: _____

16. SIGNATURE OF JUDGE: _____

17. SIGNATURE OF CLERK: _____

18. SIGNATURE OF NOTARY: _____

19. SIGNATURE OF SHERIFF: _____

20. SIGNATURE OF DEPUTY SHERIFF: _____

21. SIGNATURE OF CONSTABLE: _____

22. SIGNATURE OF JAILER: _____

23. SIGNATURE OF PRISONER: _____

24. SIGNATURE OF WARDEN: _____

25. SIGNATURE OF CHIEF OF POLICE: _____

26. SIGNATURE OF DEPUTY CHIEF OF POLICE: _____

27. SIGNATURE OF SQUAD LEADER: _____

28. SIGNATURE OF OFFICER: _____

29. SIGNATURE OF DETECTIVE: _____

30. SIGNATURE OF PATROLMAN: _____

31. SIGNATURE OF TRAFFIC OFFICER: _____

32. SIGNATURE OF INVESTIGATOR: _____

33. SIGNATURE OF ANALYST: _____

34. SIGNATURE OF CHEMIST: _____

35. SIGNATURE OF PATHOLOGIST: _____

36. SIGNATURE OF RADIOLOGIST: _____

37. SIGNATURE OF CLINICAL LABORATORY: _____

38. SIGNATURE OF PHARMACEUTICAL: _____

39. SIGNATURE OF HOSPITAL: _____

40. SIGNATURE OF NURSING HOME: _____

41. SIGNATURE OF HOME HEALTH CARE: _____

42. SIGNATURE OF LONG TERM CARE: _____

43. SIGNATURE OF SKILLED NURSING: _____

44. SIGNATURE OF ASSISTED LIVING: _____

45. SIGNATURE OF INDEPENDENT LIVING: _____

46. SIGNATURE OF TRANSITION CARE: _____

47. SIGNATURE OF RESpite CARE: _____

48. SIGNATURE OF END OF LIFE CARE: _____

49. SIGNATURE OF PALLIATIVE CARE: _____

50. SIGNATURE OF SUPPORTIVE CARE: _____

51. SIGNATURE OF COMPLEMENTARY CARE: _____

52. SIGNATURE OF INTEGRATIVE CARE: _____

53. SIGNATURE OF HOLISTIC CARE: _____

54. SIGNATURE OF WHOLEHEALTH CARE: _____

55. SIGNATURE OF WELLNESS CARE: _____

56. SIGNATURE OF PREVENTIVE CARE: _____

57. SIGNATURE OF PROMOTIVE CARE: _____

58. SIGNATURE OF PROTECTIVE CARE: _____

59. SIGNATURE OF RESTORATIVE CARE: _____

60. SIGNATURE OF REHABILITATIVE CARE: _____

61. SIGNATURE OF THERAPEUTIC CARE: _____

62. SIGNATURE OF EDUCATIONAL CARE: _____

63. SIGNATURE OF INFORMATIONAL CARE: _____

64. SIGNATURE OF EMOTIONAL CARE: _____

65. SIGNATURE OF SPIRITUAL CARE: _____

66. SIGNATURE OF CULTURAL CARE: _____

67. SIGNATURE OF LINGUISTIC CARE: _____

68. SIGNATURE OF RELIGIOUS CARE: _____

69. SIGNATURE OF ETHNIC CARE: _____

70. SIGNATURE OF RACIAL CARE: _____

71. SIGNATURE OF CLASS CARE: _____

72. SIGNATURE OF SOCIAL CARE: _____

73. SIGNATURE OF ECONOMIC CARE: _____

74. SIGNATURE OF ENVIRONMENTAL CARE: _____

75. SIGNATURE OF CLIMATE CARE: _____

76. SIGNATURE OF WEATHER CARE: _____

77. SIGNATURE OF TIME CARE: _____

78. SIGNATURE OF SPACE CARE: _____

79. SIGNATURE OF ENERGY CARE: _____

80. SIGNATURE OF MATTER CARE: _____

81. SIGNATURE OF LIFE CARE: _____

82. SIGNATURE OF DEATH CARE: _____

83. SIGNATURE OF AFTERLIFE CARE: _____

84. SIGNATURE OF REBIRTH CARE: _____

85. SIGNATURE OF TRANSFORMATION CARE: _____

86. SIGNATURE OF EVOLUTION CARE: _____

87. SIGNATURE OF PROGRESS CARE: _____

88. SIGNATURE OF INNOVATION CARE: _____

89. SIGNATURE OF DISCOVERY CARE: _____

90. SIGNATURE OF KNOWLEDGE CARE: _____

91. SIGNATURE OF WISDOM CARE: _____

92. SIGNATURE OF UNDERSTANDING CARE: _____

93. SIGNATURE OF CLARITY CARE: _____

94. SIGNATURE OF TRUTH CARE: _____

95. SIGNATURE OF REALITY CARE: _____

96. SIGNATURE OF EXISTENCE CARE: _____

97. SIGNATURE OF BEING CARE: _____

98. SIGNATURE OF DOING CARE: _____

99. SIGNATURE OF HAVING CARE: _____

100. SIGNATURE OF KNOWING CARE: _____

FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. (Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belmead d. STREET ADDRESS 3906 - 74th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter Stanley Siciak		4. DATE OF DEATH Month August Day 15 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Industry Agent		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Justice		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Anthony Siciak		14. MOTHER'S MAIDEN NAME Tecla Piasecka		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1940 - 1946 050-05-4376		17. INFORMANT Mary B Siciak Address same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) myocardial failure Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		DATE SIGNED 8/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Aug 19, 1960		22b. DATE THEREOF Aug 19, 1960		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	
23. FUNERAL DIRECTOR Shaffell		ADDRESS 4754-7th St. Wash. D.C.		24a. REC'D BY REGISTRAR Aug 18 '60	
				24b. REGISTRAR'S SIGNATURE Arthur J. House	

MEDICAL CERTIFICATION

09514

M

1

2

MARTIN LUTHER KING, JR.
FEDERAL BUREAU OF INVESTIGATION
DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
WASHINGTON, D. C. 20535

8-10-60

Prince George's
Maryland
Belmont
Cheverly
Prince George's General Hospital 3906 - 7th Ave.
August 15
30
Male
White
20 Nov. 1918
X
Walter Stanley Sloan
Dept. of Justice Pennsylvania
U.S.A.
Anthony Sloan
Teola Placencia
Yes 1960 - 1966 Mary B Sloan
same as # 2



8/16/60

James I. Boyd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9520

CERTIFICATE OF DEATH

09515
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 11 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6109 54th avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lois Middle Reese Last Smith				4. DATE OF DEATH Month August Day 11 , Year 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 17, 1913	
9. AGE (In years last birthday) 47 yrs.		10. UNDER 1 YEAR Months 4 Days 11 Hours 11 Min.		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary A C F Industries				10b. KIND OF BUSINESS OR INDUSTRY Iowa			
13. FATHER'S NAME Edward Reese				14. MOTHER'S MAIDEN NAME Edith Drushella			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Frank Smith Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) disine DUE TO (c) disine INTERVAL BETWEEN ONSET AND DEATH 24 hrs years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1953 , 19 8-11 , 19 60 , that I last saw the deceased alive on 8-11 , 19 60 , and that death occurred at 1000 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5304 Annapolis Rd DATE SIGNED 8-15-60							
ACTUAL SIGNATURE Dayton Watkins M.D.				PHYSICIAN'S NAME (Type) DAYTON O WATKINS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug 16, 1960			
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				22d. LOCATION (City, town, or county) (State) Colmar Manor Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.			
24a. REC'D BY REGISTRAR DATE AUG 19 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9510

CERTIFICATE OF DEATH

Reg. Dist. No.

09516

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville 1515-2			
f. STREET ADDRESS 14520 Columbia Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle I Last Soper				4. DATE OF DEATH Month August Day 5 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/15/1871	
9. AGE (In years last birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ridgely Randolph Carroll				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. _____			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Bronchopneumonia DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Arteriosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-13 , 19 42 to 8-5 , 19 60 , that I last saw the deceased alive on 8-4 , 19 60 , and that death occurred at 5:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 305 Prince George Street, Laurel, Maryland DATE SIGNED _____							
ACTUAL SIGNATURE J. M. Warren M.D.							
PHYSICIAN'S NAME (Type) J. M. Warren, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/60		22c. NAME OF CEMETERY OR CREMATORY Christ Church Cem.		22d. LOCATION (City, town, or county) (State) Guilford Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Donaldson				ADDRESS Laurel Md.		24a. REC'D BY REGISTRAR DATE AUG 9 60	
24b. REGISTRAR'S SIGNATURE Charles S. Adams							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

(M)

(I)

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09517

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) West Lanham Hills				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
c. LENGTH OF STAY IN lb				d. STREET ADDRESS 7019 F Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7710 Annapolis Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Edward Soper				4. DATE OF DEATH Month August Day 7th. Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1907	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53		IF UNDER 24 HRS. Hours 53 Min. 53			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver Help				10b. KIND OF BUSINESS OR INDUSTRY Trucker			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles E. Soper				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 579-16-7178			
17. INFORMANT Mrs. Jane A. Floyd				Address 6805 Beacon Pl. Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO (b) Bilateral Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pulmonary Tuberculosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) August 7, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-60		22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or country) (State) Seat Pleasant, Md.	
23. FUNERAL DIRECTOR W.W. Chambers Co				24a. REC'D BY REGISTRAR DATE AUG 11 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

Prince George's

Maryland

Prince George's

Seat Pleasant

West Landon Hills

1017 T Street

7710 Annapolis Road

August 1960

Robert

Edward

Charles

Jan. 22, 1907

Male White

U.S.A.

Maryland

Trooper

Truck Driver Help

Unknown

Charles A. Robert

6805 Beacon Pl.
Riverdale, Md.

578-16-117 Mrs. Jane A. Lloyd

Toronto

Bilateral lobar pneumonia

Pulmonary tuberculosis

James I. Boyd

James I. Boyd

August 1960

9561

CERTIFICATE OF DEATH

09518

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Pr George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37805 Allentown Kds E</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>7805 Allentown Kds E</u>				d. STREET ADDRESS <u>7805 Allentown Kds E</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lowe Edelen Steed</u>				4. DATE OF DEATH Month Day Year <u>August 6 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 1, 1868</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Jackson, Mississippi</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John J. R. Steed</u>				14. MOTHER'S MAIDEN NAME <u>Mary Pamela Edelen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Helen E. Steed</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac De compensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Degeneration</u> DUE TO (c) <u>Arterio-Sclerosis & Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 days</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8-5-60</u> , 19 <u>60</u> , to <u>5-6-60</u> 19 <u>60</u> , that I last saw the deceased alive on <u>5-5-60</u> , 19 <u>60</u> , and that death occurred at <u>5:30p</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D. <u>7519 Broadview Rd S.E.</u>							
PHYSICIAN'S NAME (Type) <u>Anna Coyne Todd M.D.</u> <u>Wash. 22, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-9-60</u>		<u>Steed's Private Cemetery</u>		<u>Allentown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levinson Bros.</u> ADDRESS <u>1661- Good Hope Rd SE Wash. 20 D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>Aug 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09520

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3402 Shepherd St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>		d. STREET ADDRESS <u>MTRANIER</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MELOA LOUISE Stennett</u>		4. DATE OF DEATH Month Day Year <u>Aug 30 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5 1918</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES STINNETT</u>		14. MOTHER'S MAIDEN NAME <u>EUFOLA GOODMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Violet Seaton</u>		1802 Van Buren St W. Hyattsville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary congestion</u> DUE TO <u>Barbituratory? intoxication</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Swallowed a number of Pills</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-30 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>9-1-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Eo. Riverdale, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>SEP 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

U-400

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]		7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]	
9. MEDICAL HISTORY [REDACTED]		10. PRESENT ILLNESS [REDACTED]		11. POST-MORTEM FINDINGS [REDACTED]		12. OTHER FINDINGS [REDACTED]	
13. SIGNATURE OF EXAMINER [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]		15. SIGNATURE OF CORONER [REDACTED]		16. SIGNATURE OF JURY [REDACTED]	
17. DATE OF DEATH [REDACTED]		18. TIME OF DEATH [REDACTED]		19. PLACE OF DEATH [REDACTED]		20. OTHER INFORMATION [REDACTED]	



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9562

CERTIFICATE OF DEATH

09519

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS (RURAL)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 134 IRVINGTON ST SW			
3. NAME OF DECEASED (Type or print) First DEBORAH Middle ANN Last STICKELL				4. DATE OF DEATH Month AUGUST Day 9 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 AUGUST 1960		9. AGE (In years lost birthday) - yrs.	IF UNDER 1 YEAR Months 1 Days 29 Hours 2	IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USAF	
13. FATHER'S NAME EDWARD B STICKELL				14. MOTHER'S MAIDEN NAME JO ANNE B HARVEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY DISEASE OF THE NEWBORN 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 29 HOURS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 AUGUST, 1960 , to 9 AUGUST, 1960 , that I last saw the deceased alive on 9 AUGUST, 1960 , and that death occurred at 9:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED JOHN R. DELAHUNTY M.D. ANDREWS AFB HOSPITAL MARYLAND							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) JOHN R DELAHUNTY CAPT USAF MC ANDREWS AFB WASH 25 DC 9 AUGUST 60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 15, 60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co Bowie, Md				24a. REC'D BY REGISTRAR DATE AUG 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Fries	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050255XV3

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9521

09521

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>Shr. 50 men</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weland Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stowe</u>				4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-60</u>	9. AGE (In years lost birthday) <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>3</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert S Stowe, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Eunice Stowe Pipkin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>hosp. records.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity -</u> <u>769-55</u> DUE TO <u>Excess of pregnancy of mother week</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 19</u> 19 <u>60</u> to <u>Aug 19</u> 19 <u>60</u> , that (I) (we) lost the deceased alive on <u>Aug 19</u> 19 <u>60</u> , and that death occurred at <u>3:45</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>L W Malin</u> M.D.				22b. DATE SIGNED <u>8-19-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>L W Malin MD</u>				22d. ADDRESS <u>Riverdale, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 25 '60</u> DATE	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09522

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>HENRY</u> Last <u>Talbot</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 2nd 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAPER HANGER</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NONE</u>		17. INFORMANT Address <u>DELORES R. COLLINS 1853 MINTWOOD WASH. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>2 weeks</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1</u> 19 <u>60</u> to <u>Aug. 6</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug. 6</u> 19 <u>60</u> , and that death occurred at <u>12:35 P.M.</u> because of the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. C. James Duke</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dr. C. James Duke, M.D.</u>				22d. ADDRESS <u>6607 Riverdale Road, Riverdale, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/15/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATL CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>SUITLAND-12600 LG, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS Co.</u>				ADDRESS <u>WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>AUG 11 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Carlton S. H...</u>			

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250

OFFICE OF THE ASSISTANT ATTORNEY GENERAL
WASHINGTON, D. C. 20540

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[illegible text follows]

9563

CERTIFICATE OF DEATH

09523

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
c. LENGTH OF STAY IN 1b four years		d. STREET ADDRESS 3912 - 4th Street North	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Loretta Middle D. Last Teegarden		4. DATE OF DEATH Month August Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Patrick Bracken		14. MOTHER'S MAIDEN NAME Anna Flanagan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT Sacred Heart Home, W. Hyattsville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS e DUE TO MYOCARDIAL INFARCTION (b) DUE TO Hypertensive heart disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 36 hrs 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 7, 1956, to Aug 3, 1960, that I last saw the deceased alive on July 27, 1960, and that death occurred at 8:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas F Collins M.D. 3245 - Wilson Blvd. 8-3-60 THOMAS F. COLLINS MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/8/1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE For Fitzgerald Funeral Home		24a. REC'D BY REGISTRAR DATE AUG 5 '60	
24b. REGISTRAR'S SIGNATURE C. L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09524

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Boulevard Height's			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 1 4809 Ellis St. S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julius Middle George Last Teias				4. DATE OF DEATH Month August Day 2 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-93		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Teias				14. MOTHER'S MAIDEN NAME Celia Pipe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT John S. Teias		Address Same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute pul. cong. edema DUE TO (b) Arteriosclerotic heart dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-28 19 60 to 8-2 19 60 , that (I) (we) last saw the deceased alive on 8-2 19 60 , and that death occurred at 7:10 PM on the causes and on the date stated above.							
22a. SIGNATURE C. James Duke				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/3/60	
22c. PHYSICIAN'S NAME (Type) C. James Duke				22d. ADDRESS 5705 18th Ave Hyattsville, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-5-1960		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l		23d. LOCATION (City, town, or county) (State) Suitland, Md	
24. FUNERAL DIRECTOR'S SIGNATURE R. G. Mattingly				ADDRESS 131-11th St		25a. REC'D BY REGISTRAR DATE AUG 4 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1938

10501

CERTIFICATE OF DEATH

Place of Birth

Occupation

Date of Death

Place of Death

Age

Cause of Death

How long ill

Where deceased resided

Signature

Witness

Physician

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09525

9502

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A.</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOTHIAN</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENERAL HOSP.</u>			d. STREET ADDRESS <u>02X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>C.</u> Last <u>Thames</u>			4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-87</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Lewis Chaney</u>			14. MOTHER'S MAIDEN NAME <u>Maria Stallings</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Lou Semel- Upper Marlboro, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Embolus from Coronary Infarction</u> DUE TO (c) <u>Arteriosclerotic Coronary Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u> <u>5 days</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>60</u> to <u>18 Aug</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>18 Aug</u> 19 <u>60</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert B. Sasscer M.D.</u>		22b. DATE SIGNED <u>8/18/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert B. Sasscer, M.D.</u>	
22d. ADDRESS <u>Upper Marlboro, Md.</u>		22e. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u>			
22f. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		22g. REGISTRAR'S NAME <u>Arthur S. Frank</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/21/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Smithville Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Smithville, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home-Upper Marlboro</u>					

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08552

CERTIFICATE OF DEATH

08505

(1)

(1)

For information from the Bureau of Health
3000

MARYLAND STATE DEPARTMENT OF HEALTH

9322

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09526

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Melvin First Thomas Middle Thomas Last				4. DATE OF DEATH Month August Day 11 , Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1903		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Town of Laurel		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah Thomas				14. MOTHER'S MAIDEN NAME Mary Elizabeth Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 16 3553		17. INFORMANT Mrs. Melvin Thomas, Laurel, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Immed. 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/2/60 , 19 60 , to 8/11 , 19 60 , that (I) (we) last saw the deceased alive on 8/11 , 19 60 , and that death occurred at 8/11 , 19 60 , from the causes and on the date stated above.							
22a. SIGNATURE Frank Weaver, Jr.				22b. DATE 8/14/60		22c. PHYSICIAN'S NAME (Type) FRANK WEAVER, JR.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Aug 15, 1960		23c. NAME OF CEMETERY OR CREMATORY Ing Hill Cemetery Laurel Md		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE De Witt Donaldson, Laurel, Md.				25a. REG'D BY REGISTRAR AUG 11 1960		25b. REGISTRAR'S SIGNATURE Arthur B. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
9503
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09527

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eugene Middle Thompson Last Thompson				4. DATE OF DEATH Month August Day 6 Year 1960			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 Oct. 1863	
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Chapman Thompson				14. MOTHER'S MAIDEN NAME Catherine Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Francis L. Thompson Rt. 1, Box 687A, Clinton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Carcinoma toxis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic Carcinoma DUE TO (c) Bronchogenic Carcinoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 24-hr INTERVAL BETWEEN ONSET AND DEATH ? 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 4 19 60 to Aug. 6 19 60 , that (I) (we) last saw the deceased alive on Aug. 6 19 60 , and that death occurred at 12:45 AM from the causes and on the date stated above.							
22a. SIGNATURE C. James Duke				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/7/60	
22c. PHYSICIAN'S NAME (Type) Dr. C. James Duke, M.D.				22d. ADDRESS 6607 Riverdale Road, Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 9, 1960		23c. NAME OF CEMETERY OR CREMATORY St. John		23d. LOCATION (City, town, or county) (State) Clinton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE North Funeral Home, Waldorf Md				ADDRESS Waldorf Md		25a. REC'D BY REGISTRAR DATE AUG 10 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1957

CERTIFICATE OF DEATH

9503

(M)

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to the quality of the scan.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09528

9511 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS 211 Rita Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Laura Middle Wallace Last Wallace				4. DATE OF DEATH Month August Day 11 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William C. Green				14. MOTHER'S MAIDEN NAME Prudence A. Simpkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Apoplexy DUE TO (c) Hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old - Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/5 , 19 60 to 8/11 , 19 60 , that I last saw the deceased alive on 8/11 , 19 60 , and that death occurred at 10:37 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John M. Warren, M.D. ACTUAL SIGNATURE John M. Warren, M.D. PHYSICIAN'S NAME (Type) 305 Prince George Street, Laurel, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 15, 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem		22d. LOCATION (City, town, or county) (State) Gloucester City New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Sanderson, Laurel, Md.				24a. REC'D BY REGISTRAR DATE AUG 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10-25

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1111

Age 50.10

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. RACE White		4. DATE OF BIRTH 1891		5. PLACE OF BIRTH Baltimore, Md.	
6. CITY OF DEATH Baltimore, Md.		7. COUNTY OF DEATH Baltimore		8. STATE OF DEATH Maryland		9. DATE OF DEATH 1941		10. PLACE OF DEATH Home	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. MEDICAL HISTORY None		14. OCCUPATION None		15. EDUCATION None	
16. SIGNATURE OF DECEASED None		17. SIGNATURE OF WITNESS None		18. SIGNATURE OF PHYSICIAN None		19. SIGNATURE OF CLERK None		20. SIGNATURE OF JURY None	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF WITNESS None		23. SIGNATURE OF PHYSICIAN None		24. SIGNATURE OF CLERK None		25. SIGNATURE OF JURY None	
26. SIGNATURE OF DECEASED None		27. SIGNATURE OF WITNESS None		28. SIGNATURE OF PHYSICIAN None		29. SIGNATURE OF CLERK None		30. SIGNATURE OF JURY None	
31. SIGNATURE OF DECEASED None		32. SIGNATURE OF WITNESS None		33. SIGNATURE OF PHYSICIAN None		34. SIGNATURE OF CLERK None		35. SIGNATURE OF JURY None	
36. SIGNATURE OF DECEASED None		37. SIGNATURE OF WITNESS None		38. SIGNATURE OF PHYSICIAN None		39. SIGNATURE OF CLERK None		40. SIGNATURE OF JURY None	
41. SIGNATURE OF DECEASED None		42. SIGNATURE OF WITNESS None		43. SIGNATURE OF PHYSICIAN None		44. SIGNATURE OF CLERK None		45. SIGNATURE OF JURY None	
46. SIGNATURE OF DECEASED None		47. SIGNATURE OF WITNESS None		48. SIGNATURE OF PHYSICIAN None		49. SIGNATURE OF CLERK None		50. SIGNATURE OF JURY None	
51. SIGNATURE OF DECEASED None		52. SIGNATURE OF WITNESS None		53. SIGNATURE OF PHYSICIAN None		54. SIGNATURE OF CLERK None		55. SIGNATURE OF JURY None	
56. SIGNATURE OF DECEASED None		57. SIGNATURE OF WITNESS None		58. SIGNATURE OF PHYSICIAN None		59. SIGNATURE OF CLERK None		60. SIGNATURE OF JURY None	
61. SIGNATURE OF DECEASED None		62. SIGNATURE OF WITNESS None		63. SIGNATURE OF PHYSICIAN None		64. SIGNATURE OF CLERK None		65. SIGNATURE OF JURY None	
66. SIGNATURE OF DECEASED None		67. SIGNATURE OF WITNESS None		68. SIGNATURE OF PHYSICIAN None		69. SIGNATURE OF CLERK None		70. SIGNATURE OF JURY None	
71. SIGNATURE OF DECEASED None		72. SIGNATURE OF WITNESS None		73. SIGNATURE OF PHYSICIAN None		74. SIGNATURE OF CLERK None		75. SIGNATURE OF JURY None	
76. SIGNATURE OF DECEASED None		77. SIGNATURE OF WITNESS None		78. SIGNATURE OF PHYSICIAN None		79. SIGNATURE OF CLERK None		80. SIGNATURE OF JURY None	
81. SIGNATURE OF DECEASED None		82. SIGNATURE OF WITNESS None		83. SIGNATURE OF PHYSICIAN None		84. SIGNATURE OF CLERK None		85. SIGNATURE OF JURY None	
86. SIGNATURE OF DECEASED None		87. SIGNATURE OF WITNESS None		88. SIGNATURE OF PHYSICIAN None		89. SIGNATURE OF CLERK None		90. SIGNATURE OF JURY None	
91. SIGNATURE OF DECEASED None		92. SIGNATURE OF WITNESS None		93. SIGNATURE OF PHYSICIAN None		94. SIGNATURE OF CLERK None		95. SIGNATURE OF JURY None	
96. SIGNATURE OF DECEASED None		97. SIGNATURE OF WITNESS None		98. SIGNATURE OF PHYSICIAN None		99. SIGNATURE OF CLERK None		100. SIGNATURE OF JURY None	

DO NOT WRITE IN THESE SPACES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9446

CERTIFICATE OF DEATH

09529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr Geor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> 40	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4910-TAYLOR STREET</u>		d. STREET ADDRESS <u>4910 Taylor St.</u> 1	
3. NAME OF DECEASED (Type or print) <u>William Thomas Ward</u> First Middle Last		4. DATE OF DEATH <u>Aug 13 1960</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 Aug 1882</u> 77 yrs.
9. AGE (In years, last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westminister Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Franklin Ward</u>		14. MOTHER'S MAIDEN NAME <u>Heddie Missouri Hunter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Claudia C. Ward Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X Congestive failure of senile myocarditis</u> DUE TO (b) <u>Left hemiplegia</u> DUE TO (c) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>30 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , to <u>13 Aug</u> , 19 <u>60</u> that I last saw the deceased alive on <u>11 Aug</u> , 19 <u>60</u> , and that death occurred at <u>5 a. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Mattingly M.D.</u> M.D. <u>2200 Rhode Is. Ave. N.E.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Thomas E. Mattingly, M.D.</u> <u>Wash. 18, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Burial Aug 15-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sennett Bros. 1661-9d Howard</u> ADDRESS <u>SE Wash DC</u>		24a. REC'D BY REGISTRAR <u>AUG 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

5124

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09530

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Langley Park c. LENGTH OF STAY IN b 1209 Ruatan St. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1209 Ruatan St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park d. STREET ADDRESS 1209 Ruatan St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl Faith Waters		4. DATE OF DEATH Aug. 10, 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1920
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Dental	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jesse Waters		14. MOTHER'S MAIDEN NAME Self	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 578-24-2339	
17. INFORMANT Margaret Waters		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Smothering DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Secured a plastic bag over his head	
20c. TIME OF INJURY 4:00 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Langley Park P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED 8/11/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16, 1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR AUG 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. K...			

FOR SALE
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8804

Prince George
Lanely Park
1209 Ruston St.
Male
Technician
Jesse Peters
Yes

Prince George
Lanely Park
1209 Ruston St.
Waters
January 26, 1950
Georgia
Self
Margaret Waters home as 2

Prince George
Lanely Park
1209 Ruston St.
Waters
January 26, 1950
U. S. A.
Self

Asphyxia
Smothering

Secured a plastic bag over his head

8:50 PM
x Home
Lanely Park P. O. Va.
x

8/11/60

James I. Boyd

Serial Lang. 10, 1960 Arlington National
V. W. CHAMBERS CO., Riverdale, Md.
Arlington, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9565
CERTIFICATE OF DEATH

Reg. Dist. No. 09531

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS(RURAL) c. LENGTH OF STAY IN 1b 34 HOURS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON DC 47 X -3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WEBB		4. DATE OF DEATH Month Day Year AUGUST 9 1960	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 AUG 1960
9. AGE (In years lost birthday) yrs. 1 10 00		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM M WEBB		14. MOTHER'S MAIDEN NAME YUKO TAKEDA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	
INFORMANT RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO atelectasis of lungs Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Prematurity (c) INTERVAL BETWEEN ONSET AND DEATH 34 HOURS 34 Hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/7 to 8/8, 1960 that I last saw the deceased alive on 8/8, 1960, and that death occurred at 0455 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF HOSPITAL ANDREWS 9 August 1960 ACTUAL SIGNATURE Arnold A Abramson M.D. PHYSICIAN'S NAME (Type) ARNOLD A ABRAMSON CAPT USAF MC USAF HOSPITAL ANDREWS ANDREWS AFB WASH 25			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-11-60	
22c. NAME OF CEMETERY OR CREMATORY D. C. Morgue		22d. LOCATION (City, town, or county) (State) Washington, D. C. DC	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 12 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2826

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9504

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09532

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nana Middle Garfield Last Weese				4. DATE OF DEATH Month August Day 31 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1882		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry J. Lark				14. MOTHER'S MAIDEN NAME Eliza Brewer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wm. Twigg Address 7368 Allentown Rd. Washington			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia Secondary to 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Peritonitis DUE TO (c) Perforation of Rectosigmoid + Gangrene PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal obstruction						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG 29, 1960 to AUG 31, 1960 that (I) (we) last saw the deceased alive on AUG 30, 1960 and that death occurred at 4, 15 AM from the causes and on the date stated above.							
22a. SIGNATURE William D. Rosson M.D.				22b. ADDRESS 5304 Annapolis Rd. Bladensburg, Maryland			
22c. PHYSICIAN'S NAME (Type) W. D. Rosson, M.D.				22d. ADDRESS 5304 Annapolis Rd. Bladensburg, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 3, 1960		23c. NAME OF CEMETERY OR CREMATORY Pinto Mennonite Cem.		23d. LOCATION (City, town or county) (State) Pinto, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George,				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR SEP 6 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kiana			

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BP

9504

CERTIFICATE OF DEATH

County of _____ State of _____
I, _____, Clerk of the County of _____, do hereby certify that _____
was born _____ at _____
and died _____ at _____
Cause of death _____
Buried _____ at _____
Witness my hand and the seal of said County this _____ day of _____ 19____.

1

CLERK

SEAL

CLERK

SEAL

CLERK

SEAL

CLERK

SEAL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

9505

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>No fixed address</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLAUDE</u> Middle <u>WELCH</u> Last <u>WELCH</u>		4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 16 1913</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Bell Welch</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Medley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>William Welch</u> Address <u>Bowie Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO <u>5410</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Peritonitis</u> DUE TO <u>1 day</u> (c) <u>Ruptured Duodenal ulcer</u> DUE TO <u>1 day</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasco Sons Hyattsville Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>AUG 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9566

CERTIFICATE OF DEATH

09535

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs (RURAL) 22 hrs.		c. LENGTH OF STAY IN 1b WASHINGTON DC 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US H F Hospital, Andrews HFB		d. STREET ADDRESS 2905 POMEROY RD SE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JENNIFER Middle ANNETTE Last Williams		4. DATE OF DEATH Month August Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 August 1960
9. AGE (In years lost birthday) yrs. 22		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EARL L. WILLIAMS		14. MOTHER'S MAIDEN NAME SHIRLEY L ELLIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FROM RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762-5 DUE TO Prematurity Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atelectasis of lungs (c) 22 hrs. 22 hrs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-4, 1960, to 8-4, 1960, that I last saw the deceased alive on 8-5, 1960, and that death occurred at 1205 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis E Potvin		ADDRESS (Street, city or town, state) DATE SIGNED 5 August 1960	
PHYSICIAN'S NAME (Type) LOUIS E POTVIN USN MC		USAF HOSP ANDREWS AFB WASH 25 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-5-60	
22c. NAME OF CEMETERY OR CREMATORY Morgue		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

CERTIFICATE OF DEATH

8508

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

INDUSTRY

OCCUPATION

RELIGION

HAIR

EYES

100

100

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMPT SPRINGS (RURAL)		c. LENGTH OF STAY IN 1b 8 HRS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON, DC	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		47x-3	
3. NAME OF DECEASED (Type or print) First JOYCE Middle ELLEN Last WILLIAMS		4. DATE OF DEATH Month AUGUST Day 4 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 AUGUST 1960	9. AGE (In years lost birthday) yrs. 4	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USAF		13. FATHER'S NAME EARL L WILLIAMS		14. MOTHER'S MAIDEN NAME SHIRLEY L ELLIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NA (If yes, give war or dates of service) NA		16. SOCIAL SECURITY NO. NONE		INFORMANT Address FATHER SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXTREME PREMATUREITY 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) ATELECTASIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH 8 HRS 8 HRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from 4 AUGUST , 19 60 to 4 AUGUST , 1960, that I last saw the deceased alive on 4 AUGUST , 19 60 , and that death occurred at 1030A M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Arnold A. Abramo</i> M.D.		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS		DATE SIGNED 4 AUGUST 1960	
PHYSICIAN'S NAME (Type) ARNOLD A ABRAMO, CAPT USAF MC		USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-5-60		22c. NAME OF CEMETERY OR CREMATORY Morgue	
22d. LOCATION (City, town, or county) Washington, D. C.		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS _____		24a. REC'D BY REGISTRAR DATE AUG 9 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hunt</i>	

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9441

CERTIFICATE OF DEATH

Reg. Dist. No.

09537

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b 1 MONTH			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HYATTSVILLE CONVALESCENT & REST HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle ANNA Last WITTIG				4. DATE OF DEATH Month 8 Day 10 Year 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-11-76	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? Germany							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. -----			
17. INFORMANT SON Address Rudolph M. Wittig-5002-54-Hyattsville							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DEHYDRATION & MALNUTRITION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ? CANCER THYROID INTERVAL BETWEEN ONSET AND DEATH 10 DAYS MANY YEARS ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from AUG. 1, 1960 , to AUG. 10, 1960 , that I last saw the deceased alive on AUG. 10, 1960 , and that death occurred at 5 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 405 SHERIDAN ST. HYATTSVILLE MD. DATE SIGNED 8/10/60							
ACTUAL SIGNATURE Henry R. Wolfe				PHYSICIAN'S NAME (Type) Henry R Wolfe			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 8/13/60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory	
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR AUG 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9250

CERTIFICATE OF DEATH

9250

Princess George

Hyndsville

Hyndsville, the Government of the State of New York

Emma

W

Housewife

Hyndsville

Ralph M. W. W. W.

No

Denial of the State of New York

Hyndsville

Hyndsville

Hyndsville

Hyndsville

Hyndsville

Hyndsville

Hyndsville

Hyndsville

may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09538

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Dale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				d. STREET ADDRESS <u>Box 104</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William L.</u> Middle <u>Wood</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-4-88</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>		IF UNDER 24 HRS. Hours <u>71</u> Min. <u>71</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Wood</u>				14. MOTHER'S MAIDEN NAME <u>Emma R</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Metastasis to Liver</u> (c) <u>+ Brain</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> to <u>8-20</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8-20</u> 19 <u>60</u> and that death occurred at <u>5:00 P.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Oliver E Thompson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>901 Pershing Dr., S.E. Wash.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 23, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Masche Son</u>				ADDRESS <u>Hjattenille Rd</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 25 60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Smith</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9568

CERTIFICATE OF DEATH

09539
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS (RURAL) c. LENGTH OF STAY IN lb 8 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY P. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC d. STREET ADDRESS 3130 PARKWAY TERRACE DR e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM E WOODS				4. DATE OF DEATH Month Day Year AUGUST 22 1960			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 NOVEMBER 1906	
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF		11. BIRTHPLACE (State or foreign country) KANSAS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W S WOODS				14. MOTHER'S MAIDEN NAME MAUDE WELCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. HAZEL E WOODS		17. INFORMANT Address SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 DAYS 8 DAYS							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 AUGUST 1960 to 22 AUGUST 1960 , that I last saw the deceased alive on 22 AUGUST 1960 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED USAF HOSP ANDREWS 22 AUGUST 1960							
ACTUAL SIGNATURE Albert D Carilli M.D. USAF HOSP ANDREWS				DATE SIGNED 22 AUGUST 1960			
PHYSICIAN'S NAME (Type) ALBERT D CARILLI, CAPT USAF MC				USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 Aug. 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Belleville, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi ADDRESS Rinaldi Funeral Home, Inc. 816 H St., NE, Wash. 2, DC				24a. REC'D BY REGISTRAR DATE AUG 26 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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CENTRAL AIR OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9506

CERTIFICATE OF DEATH

09540

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 10 Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Bowie Race Track Road			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Woodson Last Woodson				4. DATE OF DEATH Month Aug. Day 19 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1960	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Woodson				14. MOTHER'S MAIDEN NAME Mary Ellen Queen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Prematurity DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 19, 1960 to Aug. 19, 1960 , that (I) (we) last saw the deceased alive on Aug. 19, 1960 and that death occurred at 12:25 A.M. The causes and on the date stated above.							
22a. SIGNATURE <i>John Perkins</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.	
22d. ADDRESS 5103 Hamilton St. Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8-24-60		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly, MARYLAND		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W. Penn, Jr.</i>				25a. REC'D BY REGISTRAR SEP 7 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

9569

09541

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum				c. LENGTH OF STAY IN 1b ?			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5810 Riggs Rd.				d. STREET ADDRESS 5810 Riggs Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Lillian F. Young				4. DATE OF DEATH Month Day Year Aug 17 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/7/85	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government Treasury Section				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME J. Spencer Frazier				14. MOTHER'S MAIDEN NAME Minnie Morgan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Helen I. Pudney				Address 5810 Riggs Rd. Chillum, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Acute congestive heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma (Pulmonary) high blood with extensive metastasis							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D.C.				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/25 1960 to 8/17 1960, that (I) (we) last saw the deceased alive on Aug 14 1960, and that death occurred at 11 AM, from the causes and on the date stated above.							
22a. SIGNATURE F.X. Courtney				22b. DATE SIGNED Aug 17-60			
22c. PHYSICIAN'S NAME (Type) F.X. COURTNEY MD				22d. ADDRESS 5601- 4th NW Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/19/60		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	
23d. LOCATION (City, town, or county) Washington, D.C.				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co				25a. REC'D BY REGISTRAR DATE AUG 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

1954

CERTIFICATE OF DEATH

9568



DEATH CERTIFICATE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

ETHNICITY

NO.

TO



DEATH CERTIFICATE NO. 9568